12-2010

Emerging Therapist, Growing Child: Developing a Relationship with a Child with Reactive Attachment Disorder

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EMERGING THERAPIST, GROWING CHILD: DEVELOPING A RELATIONSHIP WITH A CHILD WITH REACTIVE ATTACHMENT DISORDER

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Thesis submitted to the faculty of Columbia College Chicago
in partial fulfillment of the requirements for
Master of Arts
in
Dance/Movement Therapy & Counseling

Dance/Movement Therapy and Counseling Department

December, 2010

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Abstract

Children who have had severe early childhood experiences of neglect, abuse, and/or abrupt separation from their caregivers between the ages of six months and three years are at risk for developing reactive attachment disorder. In one form of reactive attachment disorder, known as the inhibited type, the child fails to initiate interactions and positively respond in social situations. Such behaviors make it challenging for therapists to establish therapeutic relationships with children who have been diagnosed with the inhibited type of reactive attachment disorder. The purpose of this case study is to present the challenges, successes, and reactions of a neophyte dance/movement therapist in developing a therapeutic relationship during an internship experience with a 9-year-old boy who had been diagnosed with reactive attachment disorder with inhibited type characteristics.

In this qualitative case study, data was collected through case notes and reflective process notes during the five-month period in which the clinician worked with the child. Attachment theory was then used to examine the process in which dance/movement therapy was utilized. Kestenberg Movement Profile and cognitive behavioral techniques are also discussed in the course of providing treatment to the child. During the time this case study was conducted, significant progress was made by the child in his ability to relate to the therapist and to the other adults working with him in a residential treatment facility.

Acknowledgements

First and foremost, I give my utmost gratitude to the client who has made this case study possible. I want to thank him for opening up to me, for showing me his caring and thoughtful qualities. I would also like to thank the individuals at the facility in which he resides, specifically my site supervisor, the art therapist, and the client's primary therapist, in supporting me in the ups and downs of my internship.

I would also like to acknowledge my previous internship placement without which I would have been in the dark with the consent process. In particular, one of my supervisors, Catherine Chinnock, was realistic with me in brainstorming thesis topics. Her dedication and follow through in the foster care system led me to select her as my reader for this thesis. My thesis would not be at the place it is today without my thesis advisor, Kristy Combs. Thank you for your support and for all your valuable feedback.

Thank you to my partner, Kyle Miller and my faculty and classmates in the Dance/Movement Therapy and Counseling program at Columbia College Chicago. You have been here with me through so much change and learning in these past two and a half years. In my first year of the program, Julian Krantz, the baby boy for whom I was a nanny taught me firsthand about secure attachment and the typical progression of movement development and attunement. For the time I had with him, I am so grateful, so much so that it has unfolded into a thesis topic. In speaking of attachment, I cannot forget my own parents for supporting me as an infant and in continuing to give me the guidance and support as I embark on new adventures. Thank you for providing me the secure base from which to explore the world.

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Introduction

The work presented in this thesis highlights my experiences as an individual providing dance/movement therapy (DMT) to a child with a reactive attachment disorder (RAD) diagnosis. Utilizing a case study methodology and the theoretical perspective of attachment theory, I will examine the relationship that developed between the client and me. By looking at the relationship that was created with a child with RAD, this case study will look at how DMT facilitated the establishment of the relationship. The goal of this case study is not necessarily to evaluate the effectiveness of DMT, but rather to present the relationship that was developing between the client and me over a five-month treatment period. In summary, the primary purpose of this case study is to present my challenges and successes, as neophyte clinical therapist intern, utilizing DMT principles and techniques to facilitate the development of a positive therapeutic relationship with a child with RAD.

Motivation and Identified Problem

The impetus for this thesis began prior to my entry into the Dance/Movement Therapy and Counseling Program at Columbia College Chicago. At that time, I was an early childhood educator. As a teacher, I worked with low-income preschoolers and their families. Time and time again, I was drawn to my students with emotional and behavioral problems. As I worked more closely with each of them, their histories unfolded, and I came to find that they were also the children with the most heart wrenching pasts. It seemed that many of these students had experienced combinations of abuse, neglect, and/or separation from primary caregivers. The emotional and behavioral difficulties I witnessed in many of my students at the preschool level made me realize the importance of the role early childhood experiences play in development throughout life. Therein laid the problem: children who received inadequate care in early

childhood were going on to display severe behavior problems in later childhood. I wanted to do more to serve this problem than I could in my current position as an early childhood educator.

In the first year of graduate school I became a consistent caregiver, as a nanny for an 8-month-old baby boy. I was applying my education to his growth and development, witnessing the developmental progression of his movement and experiencing firsthand the formation of an early attachment relationship. When I began an internship where I would have an opportunity to work with adolescent mothers, I desired to share my experiences and knowledge of attuning and being in relationship with a young child with them. Many of the adolescents served in this organization had not had positive interactions with their own caregivers in early childhood. I became more interested in attachment theory and the importance of establishing a connection with a primary caregiver in the first years of life. In essence I wanted to take what I had learned about the importance of early childhood relationships and use it toward preventative measures. It was my hope that by teaching young mothers how to attune to and care for their children, perhaps I could help to prevent the cyclical nature of individuals with poor attachment relationships also raising children with poor attachment relationships. In my initial thesis plan, I proposed the creation of a movement group that would assist adolescent mothers in forming a healthy attachment with their children.

I was unable to continue working in my original internship site for various reasons, and was therefore, unable to follow through with my initial thesis plan. In my search for a new placement, I found myself looking for a situation in which I would have ample contact with children with emotional and behavioral problems, children I remembered feeling most drawn to as a teacher. I found what I had been looking for in an internship site and began another placement at a residential treatment facility that served children with severe emotional and

behavioral difficulties. As I began to consider doing my thesis at this internship placement, I felt drawn to using the case study methodology. Utilizing the case study methodology, I could tell a story, rather than present statistics. The methodology aligns with my theoretical orientation and humanistic perspective. In addition, a case study was an option at my internship site since variables did not need to be controlled and manipulated when multiple factors are nearly impossible to account for in a residential treatment facility.

As I considered a case study further, I wondered which of my clients would best highlight my work as a neophyte clinician. From my experiences in early childhood education, I was drawn once again to attachment theory, and realized that working through issues of attachment was one of my main focuses with one of my clients. As I explored it further, I was validated on my understanding of this client's attachment difficulties as I discovered RAD had been listed as one of his diagnoses. Instead of working toward prevention, I was working with a child who had already experienced trauma in his early years and now had a plethora of mental health issues caused by those experiences. I wondered if DMT could be helpful in facilitating connection and the establishment of a positive therapeutic relationship that might assist the child in recovering from traumatic early experiences. With this particular client, the focus for therapy was to form a therapeutic relationship. Exploring this relationship would become the focus for this thesis.

Despite the fact that the client and I were experiencing tumultuous interactions, as inherent in the initial phases of establishing a therapeutic relationship with a child diagnosed with RAD, I was, nevertheless, drawn to the child being the focus of my thesis. What was it that was drawing me to this child? As a neophyte therapist, it is important to ask myself these types of questions, to wonder about my motivations in order to be aware and not let it affect the therapeutic relationship. Why had I selected this particular client for this case study? Was it just

a coincidence that he was my youngest client? Why was I so interested in attachment theory and working with younger children? Was it a coincidence that I had selected a boy?

Throughout my training as a therapist I have been challenged to evaluate my own difficult experiences and how they affect my decisions as therapist. One of my experiences, in particular, is a well-known national tragedy and has resulted in concern from my mentors. Through their guidance, I have wondered if I could subconsciously be making choices based on my own history? Was I motivated by my own experiences in adolescence when I was exposed to extreme violence of two adolescent boys who shot at my teachers and classmates while I was a student at Columbine High School? I wondered if these experiences had motivated me to want to work with younger boys who show tendencies toward violent behavior early on in life. Could tragedies such as the one that occurred at Columbine High School be prevented with early intervention prior to those difficult adolescent years?

Though my experiences as a student at Columbine High School have shaped me, I do not know for certain that they have led me to choosing a career path as a therapist working with children with emotional and behavioral difficulties. I have asked myself questions about my motivations throughout my training and process of writing this thesis. Yet, I do not have the answers. These questions of motivation are ones I will have to ask myself and be aware of throughout my career as therapist.

Methods

The work presented herein provides a case description grounded on the principles of the case study methodology. As I decided on the case study methodology, I began to record my reactions and the process in more detail than I had with my other clients. I obtained permission from the residential treatment facility where I was completing my internship to conduct the

research utilizing the notes in retrospective reflection. Since my client was a ward of the state, I also needed permission from the Department of Children and Family Services (DCFS). This entailed submitting my research to their Institutional Review Board (IRB). After they had approved the study, I was able to obtain written consent from the DCFS guardian and verbal assent from the client himself. In order to protect the identity of the client, the name of the residential treatment facility and the client's name will not be used. Instead, the client selected a pseudonym that would represent him by name for the purposes of this case study.

In analyzing this research, I reviewed case notes and my personal reflective process notes and pieced together the story of our relationship together. In utilizing the component of my personal reflective process, I also incorporated components of self-study. Given that there are two people in the relationship, not just the child, and that the story is told from my perspective, it is not without bits and pieces of myself intermixed. Additionally, I am a neophyte clinician, working to develop my skills, and as such this case study is a process of my discovery of these skills. As I became more established as a therapist, so too did I witness the amazing growth of my client. This personal component of the thesis, added tremendously to the complexity of the work. Going into the writing of this thesis, I had no idea the challenges that lay before me. In the end, I also made discoveries of my own.

Thesis Unfolds

Other parts of this case study have emerged through the process of writing this thesis. For instance, in one of the last months of my internship I took a weekend intensive elective in Kestenberg Movement Analysis (KMP), a complex system for observing movement. In many of our sessions after taking this class, with the KMP system fresh in my brain, I identified many of the movement qualities described in the system present in my client's movements. It was not

until writing my literature review that I realized this system's correlation with attachment theory. At this time, I began to apply both attachment theory and KMP to the case study.

Another component that emerged through the therapeutic process and review of the literature was the need to integrate cognitive behavioral approaches to therapy in addition to utilizing an attachment based approach. As I considered the development of the relationship with the client, I realized the importance of structure and cognitive behavioral approaches at the start of therapy, prior to the establishment of any sort of relationship. Before engaging in DMT with my client, structure first needed to be set through cognitive behavioral approaches. Once basic trust and structure were in place, it became easier for my client to interact with me through more relational and attachment based strategies utilized in DMT. In essence, integration of cognitive behavioral techniques set the stage for the use of attachment theory when working with the client.

In the next section of this thesis, I will begin by reviewing the literature on attachment theory and its relationship to KMP. The diagnosis of RAD will be presented in addition to its related behavioral symptoms and prevalence. This thesis will also review the literature on the different treatment perspectives thought to be useful in creating interventions for children with RAD, specifically cognitive behavioral approaches and attachment based approaches. The literature in relation to expressive therapy utilized with children with diagnoses similar to RAD will also be discussed. This will be extended to the literature presenting the use of DMT in addressing the issues of children with emotional and behavioral difficulties.

Literature Review

Children who have been abused or neglected are at risk for developing a plethora of mental health conditions. Their acting-out behaviors and unregulated emotional responses often

reflect their traumatic experiences and tumultuous home environments; therefore it is no wonder that 30% to 60% of children entering the foster care system exhibit clinical levels of emotional and behavioral disorders (Dore, 1999). When school-aged children who have been abused or neglected in early childhood are compared with their peers who have not been maltreated, they demonstrate significantly higher rates of mental health problems, emotional difficulties, anxiety, depression, aggression, attention difficulties, poor peer relationships, hypersexuality, developmental delays, language impairments, and suicidal and homicidal ideation (Dore, 1999; Minnis, Everett, Peolosi, Dunn, & Knapp, 2006; Reber, 1996). The children who have been abused or neglected also tend to exhibit more problematic behaviors such as withdrawing socially, hoarding and gorging food, and those related to conduct problems such as stealing, lying, destroying property, fire setting, and cruelty to animals (Dore, 1999; Reber, 1996).

Dore (1999) found that the foster care system has tended to rely on the curative powers of the foster home to provide a reparative experience for the children who have been removed from the home due to abuse and/or neglect. However, foster families are often untrained and unprepared to cope with the emotional and behavioral needs of the children they serve. They are placed in a difficult situation in which they are expected to offer love and support to a child who often displays hostility, resentment, and ingratitude for their efforts (Wilson, 2001). The emotional and behavioral acting-out symptoms that some children in foster care display often become a problem in foster care placements and in subsequent interpersonal relationships.

For many children in foster care, they are recreating the only environment and way of relating to others they know by interacting with their foster parents in ways similar to how their biological parents interacted with them. Often times, the child is unable to explicitly identify his or her thoughts and feelings. Instead, the thoughts and feelings of the child may be expressed

through behaviors that are aggressive or isolating in nature. The child pushes caregivers away as evidenced by multiple foster care placements. With each new move, the behaviors can intensify as the child re-experiences feelings of abandonment and the trauma of leaving caregivers. The child is not getting the stability and consistency he or she needs. Instead, the child experiences repeated disruption and constant change (Dore, 1999). As a result of the cycle, spurred on by traumatic pasts, many children who have been abused and/or neglected receive diagnoses such as attention deficit-hyperactivity disorder, conduct disorder, oppositional-defiant disorder, and post-traumatic stress disorder (Dore, 1999).

Attachment theory is a theoretical perspective that has been found useful in explaining why so many children who have been abused and/or neglected experience mental health difficulties. Studies support the significance of attachment theory and attachment measures in infants as predictors of psychological problems later in life (Wilson, 2001). Brennan and Shaver (1998) have found that early attachment style is correlated to later adult personality disorders. Hardy (2007) presents evidence suggesting "that a defining characteristic of personality disorder is an inconsistent and unstable sense of self that is reflected in difficulties maintaining functional and socially appropriate interpersonal relationships" (p. 29). In another study, attachment insecurity was strongly associated with borderline personality disorder (Agrawal, Gunderson, Homes, & Lyons-Ruth, 2004); and in another, childhood disturbances due to maltreatment were suggested to set the course for the development of antisocial personality disorder (Hornor, 2008). Given the evidence of early attachment problems resulting in adulthood psychopathology with poor prognoses, it is important to provide early intervention before the personality disorders are given the chance to develop in adolescence (Hardy, 2007).

In accordance with attachment theory, the attachments developed with an infant's primary caregiver in the first years of life are imperative to the development of future interpersonal relationships. So what happens, then, if a child is abused or neglected by his or her primary caregiver in those first years of life? This may result in a child developing a *disorganized attachment* style in which the child will display chaotic or disorienting behaviors in his or her caregiver's presence (Siegel, 1999). In its most extreme form, maltreatment in these early years of life may lead to reactive attachment disorder (RAD).

Expressive therapies, such as dance/movement therapy (DMT), may be useful in facilitating the formation of a therapeutic relationship with a child with a diagnosis of RAD because of the introduction of another medium to help encourage the establishment of the relationship. Nonverbal communication is our most basic form of communication; it is how caregiver and infant initially connect in those first years of life. Therefore, an individual who has experienced maltreatment in those early years would likely benefit from repatterning positive interactions through the body and non-verbal treatment methods such those utilized in DMT.

Theoretical Perspective: Attachment Theory

John Bowlby (1969) first introduced the concept of attachment theory in the 1960s. Spurred on by his volunteer work at a school for maladjusted children, Bowlby focused many of his studies on the child's early relationship with his or her primary caregiver (Bretherton, 1995). From his studies, Bowlby conceptualized the basic understanding that infant and parent are instinctually and biologically predisposed to become attached to one another, and that this attachment is necessary for the infant's survival. In particular, babies are inclined to *proximity seeking behaviors* with an identified attachment figure in situations causing them distress. Between the ages of approximately 6 months and 2 years, the child becomes attached to and

seeks out a primary caregiver who is a consistent figure in his or her life. It is now known that the development of positive attachment relationships is essential to an individual's mental health functioning. An infant's early attachment relationship provides the framework for the formation of an individual's sense of self and ability to self-regulate in future interpersonal relationships (Hornor, 2008). I will be using the basic principles of the theoretical perspective of attachment theory in a later section of this paper in the description of case study with one of my clients.

Mary Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) were the first to test attachment theory empirically by creating a research method known as the *Strange Situation.* The Strange Situation was an experimental design in which a mother would leave her 1-year-old child with a stranger. Ainsworth and her colleagues coded the interactions between mother and child before, during, and after separation to find three categorical patterns of attachment. These categories describe the ways in which children and their parents are accustomed to relating to one another and include secure, avoidant, and ambivalent attachment styles. A fourth pattern, disorganized attachment, was identified in later research (Main & Solomon, 1986) and can develop in children who have been maltreated by their parents and caregivers. According to Wilson (2001), children with a disorganized attachment style display a lack of coherent patterns in coping strategies during the separation phase of the Strange Situation. The disorganized attachment style is also the pattern the child in the subsequent case study most readily utilized with the adults in his life.

The Strange Situation is now the most widely used research method for assessment of the quality of attachment (Lieberman & Zeanah, 1995). At this point, attachment theory has become nearly synonymous with the Strange Situation and Ainsworth's work. The laboratory procedure has added immensely to the further development of attachment theory (Bertherton, 1995).

Though attachment theory is a descriptive theory in nature rather than a treatment method, it is possible to develop interventions through the theoretical understanding that early attachment relationships affect an individual's functioning in future interpersonal interactions. Understanding attachment theory and utilizing it as a basis for conceptualization of cases, "contributes to a deeper and broader level of understanding of psychiatric problems" (Hardy, 2007, p. 29).

Kestenberg Movement Profile. Less well known than the Strange Situation, Kesternberg Movement Profile (KMP) is a complex observation system that can also be used in examining the interactions between child and caregiver (Kestenberg, 1965; Loman, 1996; Sossin & Loman, 1992). This tool provides a common language for observing nonverbal communication patterns of individuals (Loman, 1996). KMP provides information about developmental phases and relationship development and is particularly useful in examining attunement and attachment relationships (Dungey, 2005; Loman, 1996). However, though valuable in examining the relationship between caregiver and child, KMP has remained largely unintegrated into attachment theory models of infant-parent psychotherapy, possibly due to the complexity and need for extensive training in using the system (Amighi, Loman, Lewis, & Sossin, 1999).

Around the time Bowlby began his work with attachment, Dr. Judith Kestenberg first began examining the movement qualities of newborn infants (Amighi et al., 1999). As Kestenberg realized her methods of observing and interpreting movement were inadequate, she began studying Laban Movement Analysis from which the KMP system is now derived (Sossin & Loman, 1992). Kestenberg also worked closely with Anna Freud in 1965 at which time the KMP system became correlated with Anna Freud's metapsychological assessment (Kestenberg,

1965; Sossin & Loman, 1992). Since then, Kestenberg and her colleagues have spent years methodologically and interpretively developing the KMP system (Sossin & Loman, 1992). With influences from both Anna Freud and Rudolph Laban, KMP explicates the connection between body and mind in the developmental process (Loman, 1996).

In her research, Kestenberg found specific movement patterns to be linked with particular developmental phases and psychological functions. A KMP profile can be used to determine whether an individual has reached the age-appropriate developmental phases through movement observation (Kestenberg, 1975). As such, areas of regression can be present in movement observed in both children and adults (Loman, 1996). This can be caused by traumatic experiences, impeding normal growth and development. The developmental trajectory becomes thwarted and maladaptive experiences can be stored in the body. These stored experiences can come across through body movement that will be observed in the KMP system (Loman, 1996).

KMP can be used in many ways. Not only is KMP based in theory, but interventions can also be created utilizing the KMP system (Loman, 1996). KMP can be used as a diagnostic assessment tool or in a pre-test, post-term form. Additionally, KMP is useful in comparing any two or more profiles, such as those of mother and child (Loman, 1996). These comparisons can elicit information about areas of interpersonal conflict and harmony (Sossin & Loman, 1992). In the case study to be discussed in a later section of this paper, KMP will be used reflectively as I discuss the movement qualities exhibited by the child with RAD.

Neurological research contributions to attachment theory. Animal research and infant studies confirm the validity of attachment theory through neuroanatomy and neurochemical events (Wilson, 2001). Alan Schore (2001), a leading researcher in the field of neuropsychology, postulates that the communication that happens between primary caregiver

and infant directly impacts the maturation of the infant's developing brain. Schore (2001) suggests that the right hemisphere and its connected structures are particularly dominant during early interactions between the infant and caregiver. Additional research supports this notion that the right hemisphere of the brain is dominant in human infants until age 3 and that it stores an internal working model of the attachment relationship that assists the child in developing strategies for affect regulation (Klorer, 2005).

Schore (1994) theorizes that interpersonal exchanges between infant and caregiver in the early years of life provide a foundation for neurological development, leading to the creation of neural networks specifically in the right hemisphere of the brain. These neural networks will influence the infant's relationships throughout life since the right hemisphere is dominant in the reception, interpretation, and communication of emotion. Optimal functioning in these areas is an essential component for the development of empathy when relating to others in the future (Berrol, 2006, Hardy, 2007). Schore (1994) also suggests that reciprocal interactions with caregivers are essential to the infant's ability to maintain homeostasis and equilibrium in the central and autonomic nervous systems. Individuals who have had early experiences with maltreatment, however, have displayed deficits in the right brain processing of social, emotional, and somatic experiences (Klorer, 2005). These deficits are illustrated, in the case study to be presented later, in the client's behavioral problems and difficulties in relating socially and emotionally.

In addition to the right hemisphere of the brain being dominant in the development of attachment relationships, the research also supports the effect of childhood trauma on right-left brain integration (Teicher, 2002). The corpus collosum is most responsible for the connection between the right and left hemispheres of the brain as it is a large bundle of neural connections

linking the two hemispheres. Teicher found that the middle parts of the corpus collosum in boys who had been abused or neglected were smaller than those of the control group. Therefore, it can be suggested that early developmental trauma will affect the ability of the right and left hemispheres to communicate with one another. Klorer (2005) supports this notion in suggesting that a child who has been maltreated has memories that are trapped in the right hemisphere of the brain. She postulates that the development of the right hemisphere essentially becomes stuck while the left hemisphere of the brain matures.

The amygdala is another key structure in the brain that contributes to emotional processing and regulation. Additional research using magnetic resonance imaging (MRI) has shown that there is a decreased amygdala size in adults who have experienced early maltreatment (Teicher, 2002). However, Berrol (2006) suggests that more research needs to be done in order to determine the extent to which early maltreatment experiences, which affect attachment formation, impede upon the normal maturation of the amygdala.

Attachment theory in relation to childhood trauma. There appears to be a strong emphasis on attachment theory when examining the social and emotional problems faced by children who have been abused and/or neglected early in life. Often times, a child who has been abused and/or neglected is removed from the care of his or her family. When this occurs, the child is undergoing a disruption of attachment with his or her primary caregiver. When the child has experienced the abuse and/or neglect with his or her primary caregiver as the perpetrator the child may become confused; he or she may still feel an attachment toward his or her caregiver regardless of the experiences they have had while in the care of his or her biological family.

According to Hardy (2007), an infant will attach to the primary caregiver regardless of the type of interactions that occur because they are instinctually driven to form attachments. The

quality of attachment, however, will be dependent on the quality of care received. In the case of a child who has a primary caregiver that is neglectful and/or abusive, he or she is likely to develop a disorganized attachment style because he or she cannot rely on his or her caregiver to provide safety (Hardy, 2007). The child must regulate the conflict between the caregiver being both the cause of distress and the child's only source of comfort from distress (Hardy, 2007). Left untreated, the disorganized attachment style established in early childhood then has a presumptive correlation with psychopathology throughout life and in later adulthood (Main, 1996).

Reactive Attachment Disorder (RAD)

Though the attachment categories derived from the Strange Situation have been useful in guiding attachment research, they are not transferable to the diagnosis of an attachment disorder. In other words, children who exhibit avoidant, ambivalent, or disorganized attachments do not automatically meet the criteria for a qualifiable attachment disorder (Wilson, 2001; Siegel, 1999). However, as noted by Wilson, individuals with clinically significant attachment difficulties do represent a subgroup of individuals with the disorganized attachment style. Officially, RAD is the only disorder directly related to attachment listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* and is recognized as one of the most severe forms of attachment disturbances (Hardy, 2007).

RAD is a childhood disorder first acknowledged in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III*) (American Psychiatric Association [APA], 1980). The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR)* identifies the criteria for RAD as a pattern of "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years"

(APA, 2000, p. 130) in conjunction with a history of pathogenic care in these first few years of life. Two subtypes of the disorder are identified:

> *Inhibited type*—persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses
>
> *Disinhibited type*—diffuse attachment as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (APA, 2000, p. 130).

The case study to be presented in the next section of this paper details the experiences providing therapy to a child with the inhibited type of RAD. Therefore, it is this type that will be the primary focus of the discussions to follow.

Of particular interest is that the *DSM-IV-TR* requires evidence of pathogenic care in order to diagnose the disorder, and thus places an emphasis on the role of psychosocial factors in the development of RAD (Wilson, 2001). According to Wilson, this criterion of prior pathogenic care was not present as criteria for diagnosis in the first appearance of the disorder in the *DSM-III*. The current *DSM-IV-TR* states that one or more of the following must evidence the pathogenic care:

1. persistent disregard of the child's basic emotional needs for comfort, stimulation, and affection;
2. persistent disregard of the child's basic physical needs; and
3. repeated changes of primary caregiver that prevent formation of stable attachments (APA, 2000, p. 130)

Though the criteria of pathogenic care are present, Hornor (2008) states that it is important to remember that a diagnosis of RAD is not automatically present when a child has been maltreated at an early age.

RAD related behaviors. As Minde (2003) points out, the *DSM-IV-TR* criterion does not include any criteria of non-attachment related behaviors associated with RAD. According to Buckner, Lopez, Dunkel, and Joiner (2008), children diagnosed with RAD are likely to exhibit higher levels of behavioral, emotional, and psychosocial problems than children without a diagnosis. Reber (1996) identified behaviors that are shared by many children diagnosed with RAD but that are not included in the current diagnostic criteria. According to Reber, children with RAD often display a lack of empathy, limited eye contact, cruelty to animals, poor impulse control, hyperactive behaviors, and abnormal speech patterns. Clinical case studies identified by Buckner et al. suggest that the diagnosis of RAD can be correlated to problems in social relatedness, delayed language and motor skill development, failure to acquire age-appropriate self-care skills, problematic eating behaviors (e.g., gorging), emotional lability, problems with attention, impulsivity, as well as oppositional behaviors.

Hornor (2008) speculated that the presence of RAD in childhood might set a precedent for a variety of long-term mental health disorders later in adolescence and adulthood. Several sources cited by Hornor supported the link between RAD behaviors and other forms of psychopathology. Hornor found that many symptoms of RAD overlap with other disorders and are identified as comorbid diagnoses or in lieu of a RAD diagnosis. Conduct disorder, oppositional-defiant disorder, attention deficit-hyperactivity disorder, post-traumatic stress disorder, and social phobia are possible diagnoses that share similar behaviors and symptomology with RAD (Hanson & Spratt, 2000; Hornor, 2008). Hanson and Spratt support a

viewpoint that the behaviors associated with RAD, but not included in the criteria for the diagnosis may be better attributed to these other diagnoses. Interestingly, in the case study presented in a subsequent section of this paper, the client has four of these comorbid disorders listed on his diagnosis.

Hardy (2007), however, points out problems with diagnosing an individual with behavioral disorders without considering the individual's attachment experiences. He speculates that addressing the behaviors without acknowledging the pathogenic care and interpersonal difficulties would lead to ineffective long-term treatment since it only looks at the behaviors without addressing what is causing them. Hardy finds that treating an individual with conduct disorder as if it were unrelated to attachment difficulties "would be similar to throwing water on the flames of a fire rather than at the base" (p. 33). Hardy finds that there might be a reduction in symptoms, but the underlying problems would still remain.

Epidemiology and risk factors. At the time of this review of the literature, there appeared to be very little statistical information in regards to the prevalence of RAD (Buckner et al., 2008; Wilson, 2001). Hornor (2008) cited an estimation of the prevalence of RAD being less than 1% of the general population. However, she also cited studies in which the rates of RAD were found to be much higher in selected high-risk populations. There are some studies examining whether children in foster care are at particular risk for developing the disorder (Buckner et al., 2008). The emerging data suggests that children in foster care are, in fact, a high-risk population. Zeahan et al. (2004) found that between 38% and 40% of the maltreated toddlers in foster care met criteria for a RAD diagnosis. Zeanah et al. included 20 sibling pairs in their study and sibling concordance with the diagnosis was found to be high at 75% amongst the pairs. This finding confirms the understanding that the disorder is a result of poor attachment

relationships during early childhood due to pathogenic care in the household. In another study involving all children from one U.S. county who entered foster care because of maltreatment before age 4 years, Zeanah and Emde (1994) found that 38% of those children had signs of RAD according to DSM criteria.

In general, the parental risk factors for a child to develop RAD are similar to the parental risk factors that make a child susceptible for placement in foster care. In essence, the *DSM* criteria state the primary risk factor for developing RAD is the presence of pathogenic care in early childhood experiences (APA, 2000). Therefore, parents at risk of neglecting and/or abusing their children also have children that are at risk for developing RAD. The parental risk factors for RAD and neglect and/or abuse of a child include a history of substance abuse or a history of mental health problems (Hornor, 2008). Mental health problems and substance abuse are also characteristic of the parents' own abusive or neglectful upbringings (Wilson, 2001).

Children of parents struggling with substance abuse, or of individuals with psychiatric disorders are at risk for developing RAD because the environments in which they are raised may be chaotic or dangerous due to parents who may be physically or emotionally unavailable to adequately respond to the needs of their children. In addition, children who have been separated from their primary caregiver for reasons such as parental incarceration or abandonment in their early years of development are also at risk for developing RAD (Hornor, 2008). Interestingly, the client that will be presented in the following case study has a history displaying the presence of all of these risk factors, including a biological mother who had been struggling with substance abuse and a psychiatric disorder as well as periods of separation from her as his primary caregiver.

Treatment Perspectives

Behavioral perspectives. Though there are a significant number of case studies addressing treatment for children diagnosed with RAD, this review of the literature did not reveal any randomized clinical trials specifically targeting the treatment of RAD (Buckner et al., 2008). Therefore, many clinicians and researchers have utilized treatment methods designed to treat disorders with similar symptoms such as the ones mentioned earlier [conduct disorder, oppositional-defiant disorder, & attention deficit-hyperactivity disorder] (Buckner et al., 2008). It is also common for clinicians to utilize treatment strategies that have been effective with children who have been abused since a history of pathogenic care is required for a RAD diagnosis (Hanson & Spratt, 2000). Interventions that have been found to be useful in reducing behavioral problems in these populations include cognitive behavioral management of mood symptoms, behavioral modification, and psychoeducation (Buckner et al., 2008, Hanson & Spratt, 2000).

Mukkades, Kaynak, Kinali, Besici, and Issever (2004) conducted a study utilizing short-term psychoeducational interventions. The treatment was designed to increase parent and child knowledge of their disorder, enhance the development of reciprocal interaction, improve communication, and develop more effective parenting skills. The study included children diagnosed with RAD and children diagnosed with autism. The children with RAD displayed significant improvements on scales measuring language and cognition, fine and gross motor skills, social interactions, and self-care skills. The children with RAD also showed significantly more improvement than the children with autism.

In a case study addressing the symptomology of a child with RAD, Buckner et al. (2008) utilized Behavior Management Training (BMT), a research-based parent-training program

focusing on helping parents improve the quality of interactions with their child by communicating behavioral expectations clearly while providing appropriate consequences. BMT has been effective in reducing problematic behaviors in children ages 6 to 11 years (Buckner et al., 2008). According to Buckner et al., BMT is "a 10-session manualized treatment program for caregivers of school-age children with behavioral problems such as defiance, aggression, and problems with attention and concentration (i.e., problems commonly seen in RAD)" (p. 291). Buckner et al., states that BMT has a psychoeducational component in which caregivers are educated about childhood misbehavior. Caregivers are then taught parenting skills and disciplinary techniques through a home-based reward system designed to increase compliance and decrease disruptive behaviors. In essence, Buckner et al. selected a cognitive behavioral approach to addressing the behavioral symptoms of RAD. Buckner et al. presented a case study in which BMT was used with a 7-year-old meeting the diagnostic criteria for RAD and her grandparents, the primary caregivers. The results of using BMT in the case study included, a decrease in the child's problematic behaviors, an increase in compliance with caregiver and teacher commands, and an increase in the child's engagement in play with age-appropriate peers.

Attachment/relational perspectives. As mentioned earlier in discussing the common characteristics of RAD with a variety of other emotional and behavioral diagnoses, there are conflicting viewpoints to addressing RAD from a purely behavioral perspective (Hanson & Spratt 2000; Hardy, 2007). One viewpoint suggests that by treating only the behaviors associated with RAD, we are failing to address the underlying cause of the disorder, the disorganized attachment difficulties. Hence, Hardy's analogy of throwing water on the flames of a fire without addressing the source of the fire. Additional perspectives find that traditional therapy with individuals with RAD may be met with a variety of barriers such as the client's

inability to profit from experience, minimal desire to change, little or no regard for authority, and poor impulse control (Wilson, 2001). Reber (1996) finds that a child with RAD may be resistant to these conventional therapies because they are based on a reciprocal relationship involving trust. A child with RAD may have difficulty engaging in this trusting relationship based on his or her past attachment experiences.

Hardy (2007) suggests that utilizing a psychotherapeutic approach that includes the development of a healthy attachment relationship to the therapist and processing traumatic events through play therapy is necessary for the treatment of children with RAD. This notion is supported by treatment focused on the core principles of attachment theory and the mirroring of an appropriate caregiving environment (Corbin, 2007; Hornor, 2008). With such a perspective it is believed that the therapist should provide consistency, environmental safety, emotional stability, and reflective interaction through attunement (Corbin, 2007; Hardy, 2007; Hornor, 2008). According to Hardy, children who develop a healthy and supportive relationship with any adult, such as a therapist, are less affected by disorganized attachments with their primary caregivers. This was my goal in the case study to be presented later; through providing a safe environment in which he was emotionally supported, I hoped that my client would form a healthy relationship with me as his therapist.

Using such methods, Corbin (2007) presented a case vignette in which a 7-year-old boy who had been diagnosed with the disinhibited type of RAD engaged in play therapy. During his work with the client, Corbin noticed themes of abandonment and vulnerability coming up in their co-constructed play. The client utilized playhouses to act out scenes of stress and danger in which he was able to regulate with the help of the therapist. After three months of play therapy,

the client's adoptive family noticed improvements in his ability to relate and attach to family members.

In another case study, Cunningham and Page (2001) described a healthy attachment relationship that developed between a therapist and a teenager in a residential treatment facility. As therapy progressed, the client began to show pleasure upon seeing the therapist, attempted to maintain proximity to the therapist, began sharing information, thoughts, and feelings spontaneously with the therapist, and displayed less anxiety upon separation from the therapist. As the positive change was seen in the therapeutic relationship, the client also began having an increase in positive behaviors outside of therapy and on the milieu.

Berlin (2001) describes a therapeutic milieu approach to treating youth with attachment disturbances in a residential treatment facility. Berlin expounds upon a model in which the clients are provided with a milieu worker to whom an attachment relationship is encouraged. The milieu worker remains within a close physical and emotional proximity to the client for a period of several weeks. Moses (2000) conducted a qualitative study in a residential treatment facility also supporting the positive effects of individualized relational approaches. Moses found that staff working with children in the study perceived individualized relationship focused interventions as more effective than standardized behavior modification interventions.

According to Corbin (2007) some research has been less supportive of attachment based relational interventions. In studies focusing on individuals not meeting RAD diagnostic criteria, it has been found that attachment styles classified as avoidant may receive limited benefit from relational interventions (Bowlby, 1969). Corbin described one finding that some children who have been neglected in early childhood have enduring relational problems throughout their development and are not receptive to replacement experiences such as therapy.

Perspectives combined. With arguments that neither cognitive behavioral therapies nor attachment based therapies fully meet the treatment needs of children with RAD, what would be the effects of combining both forms of treatment? In discussing this concept, I will expand upon BMT as presented by Buckner et al. in an earlier section of this paper. Buckner et al. (2008) presents a case study in which the cognitive behavioral techniques of BMT were the primary style of treatment. Though cognitive behavioral techniques were the focus of treatment, attunement and relational based strategies were also seen in the case study.

Buckner et al. (2008) utilized BMT with the caregivers of a 7-year-old girl with characteristics of RAD. BMT is a 10-step treatment program for caregivers of school-age children with behavioral problems. Typically, caregivers meet with the therapist for 10 weeks, addressing one of the steps of treatment in each session. In Step 1, caregivers are educated on factors that contribute to the child's misbehavior. Caregivers are encouraged to complete homework asking them to consider stressors that might play a role in inconsistencies of discipline. Step 2 of BMT is the implementation of a period of time, approximately 20 minutes, in which the child engages in an activity of his or her choice and the caregiver simply watches and comments on the child's positive behaviors. During Step 3, caregivers learn techniques in providing effective commands. Step 4 is the implementation of a point system designed to positively reinforce compliance in the home environment. In Step 5 disciplinary methods are introduced. During Steps 6 through 10, caregivers are presented strategies for generalizing timeouts to other misbehaviors, modifying behavior in public places, and addressing relapse prevention

Step 2 of BMT appeared to utilize both attachment theory principles and cognitive behavioral principles. During a daily 20-minute period in which the child engaged in an activity

observed by the caregivers, Buckner et al. (2008) reported both caregiver and child experiencing mutually rewarding reciprocity. Though the child was receiving positive reinforcement associated with cognitive behavioral techniques, the caregiver was also taking time to attune to and reflect on the child's behaviors, similar to an appropriate caregiving environment for an infant. The child was experiencing an interaction mirroring that of an early attachment interaction in which the caregivers provided the child with consistency and reflective interaction through attunement.

As presented in Buckner et al. (2008), it appeared as though concepts of attachment theory and cognitive behavioral therapy worked together in the implementation of setting aside time in which the caregiver attuned to a child with RAD. Given this example and the strengths and weaknesses of both the attachment focused approach and the behavior focused approach, what would the effects of utilizing a combination of both intervention techniques for other children with RAD? Perhaps through the use of creative methods both attachment-based and cognitive behavioral based intervention techniques could be combined. Buckner et al. identified play therapy and art therapy as being developed as attachment-based therapeutic techniques. These and other expressive therapies may be useful in combining attachment based and cognitive behavioral based intervention techniques.

Expressive Therapies with RAD

As stated earlier, much of the experiences in the first years of life are stored in the right hemisphere of the brain (Schore, 2001). These experiences may be preverbal or nonverbal in nature. The right hemisphere and other associated structures of the brain store the experiences in implicit memory (Klorer, 2005). Therefore, it makes sense to utilize strategies promoting the use of this right hemisphere of the brain such as those involving creativity to address the treatment

goals of individuals with RAD (Gil, 2006; Klorer, 2005; Schore, 2001, Siegel, 1999). Thus art therapy, play therapy, sandplay therapy, dance/movement therapy, touch therapy, eye movement therapy, and other expressive therapies may be necessary components to treating a child with RAD (Gil, 2006; Klorer, 2005). Working to address issues associated in the right hemisphere of the brain, expressive therapists can help facilitate the movement of clients toward right-left brain integration.

Currently, there are limited documented studies in the use of expressive therapies with children with RAD. In one publication, P. Gussie Klorer (2005), an art therapist with 25 years experience providing therapy to severely maltreated children states that she has "come to believe that nonverbal, expressive therapy approaches are highly effective interventions for this population because they do not rely on the client's use of left brain language for processing" (p. 216). Klorer presents a case study involving a child with RAD and her experiences with art therapy. In the case study, "Tammy," who had been abused during her preverbal stages of development utilized art to work through her attachment difficulties. One artistic creation was that of a life-sized doll she used to symbolically develop a relationship with her foster parents. Another creation was that of an urn that essentially symbolized the letting go of her biological mother. Several months after this art project, Tammy was adopted. Though Tammy was never able to verbalize the meaning of her artwork, she appeared to be working through her trauma utilizing creative right brain processes.

William Shennum (1987) published an article claiming the positive effects of both art and dance therapies in a residential treatment center. Shennum conducted research in which he controlled, for a period of six weeks, the number of expressive therapy sessions per week children received in a residential treatment center in Los Angeles County. Shennum purported

that greater amounts of expressive therapies reduced children's levels of emotional unresponsiveness and acting-out behavior. Shennum also discussed the need for further research on the use of expressive therapies in residential treatment centers. To my knowledge, this research has not continued.

Dance/Movement Therapy (DMT) as a Treatment Method

A derivative of expressive therapy, DMT is a type of psychotherapy that focuses on the body and the way it moves both functionally and expressively (Goodill, 1987). In addressing the attachment relationship and experiences, DMT is particularly useful since infants and young children communicate first through nonverbal communication (Loman, 1996). Meekums (2008) suggested that DMT could be particularly suitable for children with emotional and communication difficulties. Goodhill finds that because abuse and neglect happen to the body physically before affecting the psyche, dance/movement therapists have an advantage in providing body based healing before verbal processing begins. As with RAD, there are cases in which trauma happens during early preverbal periods in life, in which case, Goodhill states, it is difficult, if not impossible for a child to process these traumas verbally. Again, DMT can be beneficial in attending to preverbal traumatic memories by addressing them through movement rather than verbal processing.

Cynthia F. Berroll (2006), PhD and board certified dance/movement therapist, presented the connection between DMT and the neurological components of attachment theory. Berroll pointed out the similarities between the common concept of *mirroring* known to dance/movement therapists and a concept known as *mirroring* that neuroscientists describe as occurring in the attachment relationship between infant and caregiver. These mirroring qualities are seen as part of preverbal communication between caregiver and infant and include gestures,

postures, and facial expressions. As stated by Berroll, the infant is able to internalize the attunement qualities from his or her primary caregiver and this in affect helps to nurture the infant's "evolving empathic process" (p. 309). Though mirroring is not always the imitation of behaviors, the infant and caregiver are achieving a shared affect state. Dance/movement therapists attempt the same process with their clients by mirroring a client's postures, gestures, and movement qualities. Similar to mirroring between caregiver and infant perhaps the mirroring between dance/movement therapist and client, especially those with RAD, also create a shared affect state with their clients (Berroll, 2006).

In the process of reviewing the literature in which DMT is utilized for treating RAD, only one article was found specifically addressing attachment difficulties through DMT (Dungey, 2005). In this case study, Dungey, presented two sessions in which she utilized DMT with an 8-year-old girl with attachment difficulties. Prior to these two movement sessions, Dungey had been unable to connect with the child. In the first session Dungey used DMT with the child, they created a dance together. They created movement about letting people through and letting people in. The child was the most engaged she had been in therapy up until that point. In the second session, they explored the space with one another and created animal shapes. Though the child continued to maintain a firm spatial boundary by keeping distance from the therapist, she was also able to expand her environment by exploring the room.

In her article, Dungey uses a KMP concept known as *shape-flow* to analyze the movements of the child during these two sessions. Dungey noted that these two sessions had been filled with the use of shape-flow, or the shrinking and expanding of the shapes created with the body. In the first session, the child utilized shape-flow in the shapes she made with her arms in letting people through and in. During the second session, the child formed her body into

shapes of many different animals. According to Sossin and Loman (1992), an individual's quality and exploration of shape-flow reflect his or her feelings, relatedness, or trust in others. Dungey hypothesized that perhaps the exploration of shape-flow in these two sessions signified the trust that was beginning to form in the relationship.

Further research studying the effects of DMT on children with emotional and behavioral difficulties was limited. Meekums (2008) found that very few peer-reviewed publications describing DMT with children exist. Even the research that was found appears to be dated (Goodill, 1987; Meekums, 1991; Rakusin, 1990). This is not to say that DMT is not being done with this particular population. Reasons for the lack of literature on this subject could be due to the vulnerabilities of children in general. Children in the foster care system are even more vulnerable, with complicated histories that add additional variables that cannot be controlled. Often, in conducting research with this population, children with the greatest level of emotional and behavioral difficulties are excluded from studies because of the severity of their disorders and comorbidity with additional diagnoses (Crenshaw & Hardy, 2007; Dore, 2008).

DMT using cognitive behavioral principles. In her article, Amy Rakusin (1990) supports the notion of the non-verbal aspects of DMT being useful particularly for children. Rakusin states that the therapist must often act as a guide to the child in discovering the meaning of his or her movements. Rakusin as supported by Levy (2005), noted that a therapist must be sensitive to children with emotional and behavior disorders need for structure. Rakusin found that DMT with this population must begin with boundaries narrower than boundaries for children who have not been identified as having emotional or behavioral difficulties. Utilizing behavioral based techniques, children with emotional and behavioral problems will likely benefit with boundaries that are clearly stated and enforced with consistency. Once the structure of the

sessions are clearly defined and understood by the clients, Rakusin states that there is room for flexibility and individualization in which the therapist enforces "external structure when the child's intrapsychic order is weak…. [then] suspend[s] structure when the internal ego system is strong" (p. 57). This is consistent with attachment theory and a mother providing nurturing and support as a secure base for an infant to return to in order to regulate. The need for structure in the beginning was certainly the case in my experience working with the client in the case study that will be presented later in this paper. The use of cognitive behavioral interventions facilitated structure and provided an initial sense of safety to allow for free exploration in later sessions.

DMT using attachment/relational principles. Levy (2005) provides a description of some of the work being done with several different populations, including children with special needs in her comprehensive book which details the development of the profession of dance therapy. Levy describes the work of dance/movement therapist, Suzi Tortora who developed a four-part procedure for using DMT with children. Tortora first uses techniques to attune to and mirror the movement qualities of the child, she then uses the movements as a dialogue with the child, thirdly she creates movement interventions to explore and expand the actions of the child, and finally transitions the communication from nonverbal to a verbal exchange. This four-part procedure is similar to those of attachment theory and the caregiver and infant relationship in the first years of life. Additionally, Levy describes Jane Wilson Cathcart's work with children with mental illnesses in a psychiatric facility. Particular to the issues of RAD, Cathcart focused some of her work on observing nonverbal interactions between mother and child to analyze how the personality characteristics of each contributes to and effects the child's bonding experience and general attachment.

Case studies. Sharon Goodill (1987) contributes to the understanding of what happens in DMT treatment that benefits children who have emotional and behavioral difficulties. Goodill provides case descriptions of her clinical work with abused and neglected children enrolled in a psychiatric facility serving children ages 3 to 12 with all types of behavioral and psychosocial problems. These case presentations gave examples of how DMT can help a client to develop strength and trust, obtain a healthier body and self image, express his trauma through symbols, unlock old patterns in order to establish new awareness, and share in a group setting.

In her last case description, Goodill (1987) took her reader through the therapeutic process of an 11-year-old girl who had been sexually abused. Goodill helped her client through the trust building stage, then a stage in which the child utilized symbols to process her trauma, followed by a stage in which the child explored her new self through experimentation, and then integration during a final stage in which the new self and the symbolization of trauma appeared together. The first stage of trust building was again, highly structured. The therapist introduced an exercise format to the sessions in which there was an emphasis on lower body stability through choreographed sequences. In the second stage, the client used the symbol of a ball of problems that she would either want to dump out or ignore. Though she did not name or explain the problems, the symbolic tasks allowed some emotions to surface. In the third stage, the client began to dance and create an identity through movement exploration. She worked with the feminine qualities of balletic movement in which she created stories that appeared to be related to her relationship with her father who had sexually abused her. Later her dancing took on a flirtatious manner when she asked to learn popular teen dances. In the fourth and final stage, the client began to verbally express and work through feelings related to her parents and siblings.

In addition to the published literature on DMT addressing the needs of children with emotional and behavioral problems, there have also been many master's level case studies written as theses in relationship to working with this particular population (Bell, 2006; Combs, 2005; Friedman, 1986; Gonzalez, 1993; Gorman, 1985; Grosowsky, 1983; Miller, 2001; Onderdonk, 1999; Purpello, 1996; Shaaltiel, 1988; Trainor, 1991; Visconti, 1991; Weikers, 1989). Therefore, it is well documented that there are currently dance therapists working with this particular population. In the following, I will build upon this body of work in a description of my experiences working with a child with RAD.

Case Study

Background

Personal journey. As a dance/movement therapist in training, I completed a nine-month clinical internship as an integral component of my education. I selected an internship in a community organization serving children and families in the foster care system based on my interest in this particular population. Many of my responsibilities in this placement were in administrative tasks such as documentation, sending letters, and repeated contact with caseworkers. In this placement, I found it challenging to practice my counseling and DMT skills since my clients had difficulty keeping their appointments. I felt stuck, how was I to emerge as a therapist if I did not have the opportunity to practice my skills?

Therefore, three months into my initial placement I made the difficult decision to change placements and begin anew at a residential treatment facility. In a residential treatment facility also serving children in the foster care system, client contact and gaining experience with counseling and DMT came easier since I was working in the living environment of the children to whom I was providing services. Even still, I found that my skills as a therapist would need to

emerge carefully and slowly. Though the structure was there, the skills could not be forced, but would emerge gradually over the course of my internship and writing this paper.

Residential treatment context. Once in the residential treatment facility, I began to encounter clients with a variety of psychiatric diagnoses such as RAD. Placement in a residential treatment facility is a treatment option for children diagnosed with RAD and other similar diagnoses whose behaviors are unable to be managed in less restrictive home environments. Residential treatment facilities provide a structured environment for therapeutic services when behaviors are compounded by the abuse and/or neglect children have endured with biological families or in placements with foster families. One goal of therapy in residential treatment facilities is to help equip children with relational skills that will make it possible for them to return to less restrictive home environments.

Meeting Jairo. "Jairo" (this name was selected by the client as a pseudonym), a 9-year-old Caucasian male, was a client I worked with while interning at the residential treatment facility. Jairo's previous dance/movement therapist and the expressive therapy supervisor transferred him to me in my first month observing at the facility. His previous dance/movement therapist expressed her difficulty engaging Jairo in dance/movement therapy interventions and expressed that many of the previous sessions had been spent with him playing on her computer. She told me that he had been informed that this would no longer be allowed.

A week before therapy was to begin with me, Jairo's previous dance/movement therapist introduced Jairo and I while he was on his unit. She reinforced to him that I would be his new dance/movement therapist and that he would no longer be allowed to use the computer while in session. In this first interaction, Jairo was defensive and showed signs of irritability. Jairo's unit staff suggested I help him with his math homework. He asked for a calculator and began playing

with it by asking me to challenge his multiplication abilities. When I suggested we begin working on his homework instead, he responded defensively, stating, "This is my homework." Our homework session was then interrupted by a group art therapy session, which I attended with him. In this session, I attempted to engage with him and help him with his art project. Jairo, however, remained standoffish and appeared to prefer to work on his own.

In addition to individual DMT sessions, I also saw Jairo in a weekly conflict resolution group with all of the clients on his unit. The group was co-led by the unit's primary therapist and me. Though the primary therapist was not a dance/movement therapist, I was encouraged by her to incorporate DMT interventions into group activities. Incorporating movement into the group was relatively easy, as the client were aged 8 to 12, and therefore less inhibited with moving than adolescents or adults may have been. During these group sessions, I utilized a unit that helps facilitate increased spatial awareness from the curriculum, *Disarming the Playground* (Kornblume, 2002). In total, over the five-month period I saw Jairo in 15 group sessions and 30 individual sessions, most of which incorporated DMT concepts.

Client background. Jairo had been living in the residential treatment facility one year prior to the beginning of my internship. He received many services as a part of his treatment while living in the facility, including individual, group, milieu, and recreation therapy. In addition, this facility had an expressive therapy department through which Jairo received weekly art therapy and DMT. Jairo attended a public school in the community. Prior to his referral to the residential facility, Jairo had been in approximately six different foster placements all of which failed due to his behavior problems, such as sexually acting out with his younger sister and cruelty to animals.

Jairo's social history was not unlike other children with a RAD diagnosis living in residential treatment facilities. His mother first became involved with the state's foster care system when his infant brother was born drug exposed. Jairo was 3 years old at the time. Shortly thereafter, his mother lost custody of her infant son. Jairo and his younger sister, however, remained in her custody. A year later, the family once again came to the attention of child welfare when a neighbor called the police after a domestic violence incident between Jairo's mother and her boyfriend. At this time, Jairo, at the age of 4, and his younger sister were removed from his mother's custody. The specifics of the care Jairo received in those first years of life are unclear, though many of the familial risk factors of children likely to develop RAD (Wilson, 2001) were present. These identified risk factors included his mother's history of substance abuse and a diagnosed psychiatric disorder. Jairo also experienced another short disruption in his attachment with his mother when she was arrested prior to him being removed from her custody. Results from an assessment completed in the residential facility determined that Jairo's sexually acting out behaviors were likely due to sexual abuse in his early years, though details of the abuse are unknown.

Also common with children diagnosed with RAD is the comorbidity of additional diagnoses (Hornor, 2008). In addition to RAD, Jairo was diagnosed with attention deficit disorder, post-traumatic stress disorder, general anxiety disorder, and conduct disorder. According to Jairo's chart, his behavioral symptoms have included: a history of aggression, defiance, poor impulse control, poor social skills, and sexually inappropriate behaviors such as exposing his genitals to peers. He has also displayed signs of cruelty to animals, fire setting, and a lack of remorse. While living at the facility, Jairo frequently engaged in high-risk behaviors such as repeated elopement attempts and homicidal threats. Jairo also displayed stealing and

hoarding behaviors, including the hiding of sharp objects in his room and in clothing on his body.

Though Jairo had several other diagnoses, treating the emotional problems associated with the RAD diagnosis became the focus of my work with Jairo. Due to Jairo's difficulty forming relationships and that I would only be working with him for five months, the primary goal of our therapy would be to develop a relationship. This fit with Jario's previously established treatment goal of developing safe, healthy, and mutually rewarding interpersonal relationships. Once he was able to maintain a positive relationship with another individual, my hope was that Jairo would be able to transfer that experience to other relationships, thereby allowing him to work through emotions associated with his traumatic past with his next therapist. I hoped that by improving his ability to connect to and develop empathy for other individuals there would also be a reduction in the quantity and severity of the negative behaviors Jairo displayed.

My work with Jairo also addressed other goals on his treatment plan including, improving personal boundaries and learning to respect authority figures by following rules. The weekly conflict group was where I assisted Jairo and his peers in improving personal boundaries through spatial awareness (Kornblume, 2002). Primary to all my work with Jairo was the focus on establishing respect and trust for each other. This goal was at the forefront in our first weeks of therapy together. The establishment of mutual respect was central to Jairo's willingness to follow rules and begin work toward developing of a safe, healthy, and mutually rewarding relationship.

Utilizing the Lens of Attachment Theory and KMP

Attachment theory. Through the course of describing this case study, I will be applying attachment theory to the relationship that was created between Jairo and me. As attachment theory is a descriptive theory rather than a treatment method, I will be utilizing the theory to retrospectively reflect on Jairo's behavior and the development of our relationship over a five-month period. Using attachment theory to conceptualize the development of RAD and the behaviors with which Jairo now struggles, it is important to take a close look at his past and early childhood experiences.

Due to the challenging experiences in Jairo's first years of life, it is no wonder that he struggles with relationships now in later childhood. Utilizing attachment theory to conceptualize Jairo's history, I can hypothesize that his caregivers displayed frightening or disorientating communication with Jairo during his first year of life, leading to Jairo displaying characteristics of a disorganized attachment style (Main & Solomon, 1986). In this attachment style, an infant displays chaotic or disorienting behaviors such as going toward a caregiver and then backing away (Siegel, 1999). The communications between infant and caregiver present the infant with an unsolvable and problematic situation in which the child cannot use the parent to become soothed or oriented because the caregiver is the source of disorientation (Siegel, 1999). Jairo's experiences in early childhood likely led to his current behaviors and difficulty in relating to others now in later childhood. These patterns of interacting with others were seen even in my first encounter with Jairo and his hostility toward me as we worked on his homework together.

When examining attachment theory from a neurobiological perspective, it has been found that inconsistent caregiving in early childhood may hinder development of the right brain process of internal affect regulation (Schore, 2001). Schore (1994) speculated that interpersonal

exchanges between infant and caregiver in the early years of life assist in creating neural networks in the right hemisphere of the brain. Neurologically, Jairo's interactions with his mother in those first years of life will have influenced him throughout life since they will have, in essence, affected the structure of the right hemisphere of his brain. These early experiences with maltreatment may lead to right-brain deficits in the processing of social, emotional, and somatic experiences throughout life (Klorer, 2005).

Likewise, it has been found that children with a disorganized attachment style are likely to have emotional, social, and cognitive difficulties later in life (Siegel, 1999). According to Siegel, studies have found that children with a disorganized attachment style often become hostile and aggressive with their peers and tend to develop a controlling style of interaction that make social relationships challenging for them. In Jairo, a disorganized attachment style, as a result of the caregiving he received as a young child, has likely resulted in his difficulty connecting with others and an inhibited type of the RAD diagnosis. In addition to the RAD diagnosis, it is likely that Jairo's other diagnoses have also developed due to the poor attachment experiences and resulting disorganized attachment he had in early childhood.

Kestenberg Movement Profile (KMP). In addition to exploring the relationship through attachment theory, KMP is a useful tool that aids in examining attachment even further by using a movement lens. Though KMP has generally remained unintegrated into attachment theory models (Amighi et al.,1999), it is nonetheless useful in examining the development of attachment. In particular, Dungey (2005) has found KMP to be useful in examining attunement and attachment relationships. I have selected KMP for this case study since developmental phases and psychological functions associated with the KMP system can be correlated with attachment theory. Though KMP can be utilized as theory, as a diagnostic assessment tool, and

in creating interventions (Loman, 1996), it is important to note that in this instance, I was not consciously utilizing KMP as assessment or in the interventions I utilized while working with Jairo. Similar to the use of attachment theory in this paper, I will be using KMP retrospectively in describing the behaviors and movement qualities demonstrated by Jairo in the course of therapy with one another. Through the course of this case study I will discuss some of Jairo's movement qualities through aspects of the KMP lens. I will also utilize the KMP system to describe relational aspects of Jairo and my therapy sessions during the course of our five months in therapy with one another.

One component of the complex KMP system is a concept known as *tension-flow rhythms*. These rhythms are developmental movement patterns used to express needs and drives that unfold as a child matures (Amighi et al., 1999). The patterns proceed through a sequence of psychoanalytically and psychosexually conceived developmental phases (Sossin & Loman, 1992). Tension-flow rhythms align well with attachment theory because they emerge developmentally (Loman, 1996). Tension-flow rhythms also align with attachment theory because they often develop in relationship to another person, such as the infant or child's primary caregiver. "As development proceeds through each phase, preferences for different movement patterns surface and change and are reflected in the qualities of movement which are most likely to be used" (Sossin & Loman, 1992, p. 26).

Ten of these tension-flow rhythmic patterns have been identified and correspond in dyads to the five major developmental phases identified by Anna Freud (Sossin & Loman, 1992). The tension-flow rhythms are identified as sucking and biting in the oral phase, twisting and straining in the anal phase, running and stopping/starting in the urethral phase, undulating and swaying in the inner-genital stage, and jumping and leaping in the outer-genital phase (Sossin & Loman,

1992). In examining these rhythms, it is important to note "all rhythmic patterns are evident (to greater or lesser extents) at all phases" (Sossin & Loman, 1992, p. 26) and that there is also a variety of mixed rhythms where two or more rhythms are combined. Though developmentally based, all the rhythms may be available to an infant and are present at birth (Loman, 1996). It is also important to realize that although, for example, sucking and biting appear in the oral stage, other body parts such as fingers or toes may also display these rhythms (Sossin & Loman, 1992).

The oral rhythms, both sucking and biting, are important to consider when discussing attachment since these rhythms develop primarily in the first year of life (Loman, 1996). According to Bowlby (1969) and attachment theory, the first year of life is crucial to the attachment relationship. In the initial stages of life, the sucking rhythm is particularly valuable in promoting symbiosis, attunement, and nurturing between an infant and his or her primary caregiver (Loman, 1996). The feeding process in general is a time when mother and infant can bond and begin to form an attachment. Equally important is the second part of the oral stage, the biting rhythm, when separation and boundary formation begins to develop in an infant (Loman, 1996). At this point, complete symbiosis with the caregiver is no longer necessary and the child begins to establish a sense of self.

The diagnostic and interpretive aspect of tension-flow rhythms and other aspects of the KMP system can lead to the detection of specific early developmental deficits and areas of psychological problems (Sossin & Loman, 1992). According to Loman (1996), an individual may overuse or refrain from using qualities from a phase in which trauma occurred. The developmental trajectory of the rhythms becomes disrupted. For instance, a profile in which there is significant overuse or underuse of phase-appropriate movement patterns may indicate delayed, missed, distorted, or prematurely induced developmental milestones (Sossin & Loman,

1992). A KMP diagram displaying these abnormalities may indicate developmental difficulties related to early trauma such as abuse and/or separation from a primary caregiver during a specific phase in childhood (Sossin & Loman, 1992). In my own experience at my internship, many of my clients who had experienced early traumatic experiences also experienced problems with encopresis or enuresis which could indicate traumatic experiences in the anal or urethral stages of their development creating difficulties for a person to fully develop their most basic bodily action of excretion of bodily waste. KMP interventions can be particularly useful for individuals needing to reintegrate disrupted or missing rhythms in later childhood or adulthood (Loman, 1996).

During my experience at my internship, I often observed overuse or underuse of certain tension-flow rhythms by the clients at the facility. Throughout the course of my work with Jairo, I observed many instances when he utilized oral tension-flow rhythms. The overabundance of this earlier tension-flow rhythm to develop in a 9-year-old boy is indicative of regressive behaviors. Perhaps these rhythms were unable to develop fully in his first year of life. In that first year of life, I could hypothesize that Jairo's mother did not attune to him during infancy when the oral sucking rhythm normally develops. As my relationship with Jairo developed, the oral tension-flow rhythms were observed in his behaviors and the way he interacted with me, eight years after the period in which they are normally most prominent. Detailed examples of these observations will be examined further throughout the remainder of this paper.

In the Beginning

First session. In the beginning, my supervisor displayed some concern about the unpredictability of Jairo's often unmanageable behaviors. She came in on her day off for our first session. Because her concern produced anxiety in me, I asked a few questions, "As an

intern, what do I do if a client runs?" and "Does this door to the outside in the DMT room open?" I was told to use the walkie-talkie to call for backup. Using the walkie was another anxiety producing experience for me. My anxiety coupled with my supervisor's concerns left me nervously anticipating our first session.

In this first session, my supervisor stressed the importance of laying down ground rules, in particular, reminding Jairo that we were not allowed to use the computer while in the DMT space as he had been doing in the past. With these reminders, Jairo stated that he did not want to leave his room. He asked if he could take his Game Boy. Wanting the game as a form of distraction was perhaps a protective mechanism, a wall of sorts to keep from having to interact with me relationally. In fact, even after he relinquished the Game Boy, he did not seem interested in engaging or interacting with me at all.

I had come up with an intervention I hoped would spark Jairo's interest and engage him in interacting with me. Prior to this session, I had become aware of an interest Jairo had in bugs through a conversation with another intern who recounted an interaction she had with Jairo in which he was torturing ants in his room. Though Jairo's interactions with the bugs was less than ideal, I thought I could attempt to capture his attention utilizing bugs and their habitats in a more positive way during our first session. I saw bugs as an area of interest for Jairo and a starting point from which to begin our relationship.

Once coaxed into the DMT space, I supplied Jairo with yarn and tape and introduced an intervention in which he could create a giant spider web in the room. When I excitedly began talking about spiders and pretending that we could spin webs he looked at me like I was idiotic. This memorable look became familiar in other times as well, especially whenever I brought up the idea of pretending. I found myself feeling self-conscious and insecure in these situations. In

general, being around Jairo occasionally brought up feelings of discomfort, awkwardness, and being uncertain of my worth as a person and therapist. In later discussions I had with Jairo's primary therapist and others working with him on a regular basis, I discovered that other clinicians identified similar feelings to my own in their work with Jairo. My uncomfortable feelings and theirs were likely a concept Yalom and Leszcz (2005) terms as objective countertransference, or the characteristic impact an individual has on the feelings and responses of others.

Jairo had likely experienced similar questions of his self-worth in the context of the early relationship he had with his mother. Now in other relationships, Jairo was eliciting uncomfortable feelings from those interacting with him. These feelings also prevented those of us working with him from feeling close and connected with him, and therefore protected him from intimacy and vulnerability in the relationship. In essence, Jairo was interacting with others the only way he knew how, and in doing so elicited uncomfortable feelings from otherwise healthy adults.

In this first session, I tried to not let my feelings of insecurity get the best of me and modeling for Jairo, I began throwing the yarn and connecting it across the room. Soon enough, Jairo's feigned curiosity succumbed to genuine interest. He began giving me directions, telling me exactly where he wanted the web to connect. He then became more independent, asking if he could do it himself. I attempted to remain a part of his play by pretending to be a fly caught in his web. But for Jairo, it did not appear to be about pretend play, which proved to be a challenge for us throughout our time in therapy together. Instead, it was about the string and concrete creation. Ultimately, a common interest sparked as Jairo began to verbally engage with me by sharing interesting facts about spiders. Thus our relationship had begun with the help of an

intricately woven web covering the space of the DMT room and a shared interest in the world of bugs.

Jairo and I turned the space into a magical and truly transformational wonderland. When in the past Jairo had been coming to this space to use the computer, in this intervention Jairo made the space "ours" for our newly created relationship. When it was time to end this session, the destruction of the space and the removal of the web were extremely difficult for Jairo. He argued that we should leave the spider web. Angrily, he cut the web into pieces and ignored my attempts to redirect. After he had cut them, he did not want to help clean them up and instead began punching a punching bag. This first transition to the end of the session and then back to the unit was difficult. As I reflect back, I have come to the realization that these transitions continued to be a more challenging aspect of therapy for Jairo.

In ending this session, Jairo displayed signs of an inability to regulate his emotions as is common with children who have disorganized attachment styles (Siegel, 1999). In creating the web, he also exhibited a controlling style of interaction, according to Siegel, another characteristic common in children with disorganized attachment styles. In reverting to punching at the end of the session, Jairo was utilizing the KMP oral biting tension-flow rhythm. In this case, as Jairo became dysregulated, utilizing his disorganized style of attachment, he engaged in sharp movements of cutting down the web and punching a punching bag. Interestingly, Jairo engaged this oral biting rhythm at the end of session when separation was necessary. The biting rhythm is an earlier rhythm to develop, one which a normally developing infant utilizes to establish separation from his or her caregiver (Loman, 1996).

Behavioral problems. After the second session together, I stated in a progress note, "Jairo is unable to follow redirection, my authority, or the rules of the session with respect and

compliance." Due to his behaviors, I was unable to manage the space and create a safe environment for us in the next two sessions. I had to call for back up for help in transitioning Jairo back to the unit after both sessions. During the sessions, he was rude to me, he laughed and made fun of me, he attempted to cheat at the games we played together, and he attempted to steal things from the DMT space.

In these sessions I questioned my self-worth as a therapist. His laughing and making fun of me hurt my feelings. As a former teacher, I held much importance in classroom management, maintaining control, and authority within the classroom environment. Though I had some degree of flexibility, I also needed to maintain order. I seemed to prefer this, a set structure with flexibility within that structure. Yet in this setting that was not yet established. I wondered how was it that I could not control and maintain safety for one child and myself in a therapeutic environment? I struggled with having to ask for help by calling for backup, but upon doing so, I realized that I did not have to do it alone. There was a reason Jairo and the other children were at the facility and their needs for an intensive therapeutic environment with monitoring and support were high.

Just as my skills as therapist could not be forced, I also found that I could not force Jairo's behaviors and the therapeutic process would have to emerge slowly as well. Even so, with the safety of the sessions compromised, it became impossible for us to focus treatment solely toward his goal of developing healthy relationships and instead we focused sessions toward his goal of learning to respect authority figures and follow rules. Boundaries and structure would first need to be established in order to maintain emotional and physical safety before our relationship and the DMT sessions could progress further.

In our second session, Jairo found a teddy bear in the DMT room and claimed it as his. Jairo refused to help clean up and transition out of the space, stating that he would not leave unless he could take the teddy bear. What was it about this teddy bear? Was he testing me, my willingness to provide him nurturance as a teddy bear might symbolize? This nurturance, in the form of a teddy bear, was not mine to give. Perhaps Jairo was also testing to see what he might get away with in working with a new therapist. Instead of providing nurturance through the teddy bear, I did so through calmness and a soothing vocal quality. I stood firm; he could not take the teddy bear. His emotions escalated and he became further dysregulated. His movement qualities once again reverted to the biting rhythm as it was again the point of separation, and he began to hit an exercise ball with a golf club. As others arrived after my back up call, staff assisted by removing the weapon from Jairo's hands and calming him in order for him to return to the unit. He agreed to hide the teddy bear in the DMT room until I could investigate further whether it did truly belong to him.

In the next session Jairo hid an item from the space in his pocket and then attempted to run when confronted. My supervisor was one of the staff that responded to the backup call, and restricted us from continuing our therapy sessions in the DMT space for the next three weeks due to Jairo's lack of respect for the boundaries established in the space. In being asked to remain out of the DMT room for three weeks, I felt reprimanded as a sense of guilt emerged. I continued to feel worthless and insecure as a therapist in not being able to maintain the therapeutic space with my client. Jairo acted as if he did not care and did not want to leave the unit anyway. My own feelings gave me insight as to how Jairo truly felt about being banned from the space. Perhaps Jairo felt a sense of being "bad" with no hope being instilled in his ability to do "good."

Cognitive based games. In our sessions on the unit, due to limited space, we played board games together. In the first game Jairo began to cheat and I verbally confronted this behavior. In this more physical board game, Jairo was slanting his paddle in such a way that the object he hit over to my side flung down to the table aggressively. He denied his cheating behavior. I then began to mirror back his biting rhythm type movements and he became frustrated with the game and put it away. Again, I began to doubt myself as a therapist. We did not seem to be getting anywhere in developing a relationship with one another and what felt like hatred toward me made me feel as though I was doing everything wrong. I felt the need to verbalize these feelings and address what happened in the session prior when we had been asked to conduct his sessions off the unit. Up until this point, nearly halfway through the session, the events of the session prior remained unspoken. As an emerging neophyte therapist, keeping confrontation at bay was what felt most comfortable to me. In relationships, I would appease others and ignore any problems that might be beneath the surface. Bringing conflict out into the open was an emerging skill of which Jairo helped me to understand the importance.

As I brought up the session prior, Jairo was unwilling to listen or talk about anything that happened. He asked why I waited until the middle of the session, stating that he would rather have it over with in beginning. It seemed like the events of the last session needed to be out in the open rather than ignored in order for Jairo to be comfortable in interacting with me. Interestingly, after talking about what had happened, the session and Jairo's attitude toward me seemed to have shifted dramatically. Through addressing conflict, a line of communication had been opened, thus, setting the stage for our relationship to develop even further. Though difficult to initiate, addressing challenges we had in the session prior lifted a huge weight off of both of

our shoulders and a veil of darkness was removed from the room. It was as though we were in a completely different session from the first half to the second.

In the second half of the session we began playing another game in which Jairo allowed me to teach him the rules of the game. This game required cognitive thinking and problem solving skills. Jairo displayed high intelligence and interest in learning new things. As I left the unit, Jairo excitedly came up to me, explaining the answer to the game. He was warm, engaging, and wanting to share a positive interaction with me. I was surprised and delighted by this dramatic shift. In the sessions to follow, Jairo and I built upon a common interest of our enjoyment of the cognitive based board games we continued to play together. I found Jairo to be extremely intelligent and I delighted in watching new cognitions being formulated, perhaps this was my teacher background coming forth. The first instances in which I began to feel a connection between Jairo and I were left brain based in the interactions of playing cognitive board games with one another.

Normally, in the connection between infant and his or her primary caregiver, they first connect through right brain processes, through attunement and sensing on the part of the mother (Siegel, 1999). These right brain structures are the first to develop in an infant, the first year being pivotal for right brain development (Schore, 1994). For children with RAD, such as Jairo, the right brain structures are likely unable to develop normally as they would in a caring environment. Such life experiences lead to children with RAD having difficulty with relationships based on reciprocal interactions involving trust, an important characteristic that develops in the right hemisphere of the brain (Reber, 1996).

Based on his development and earlier experiences, perhaps jumping straight into the right brain processes of connecting to another individual were too difficult for Jairo at the beginning

of treatment. Left brain based interactions such as playing board games were less vulnerable for Jairo since emotions, processes, and aspects of relationships associated with the right brain were still difficult for him. Instead of right brain to right brain, Jairo and I first connected left brain to left brain (Siegel, 1999). In a sense, the cognitive aspects of our therapy and connecting through left brain processes with one another became the starting point from which Jairo and I could begin to work through attachment and relational based therapies with one another. In establishing this foundation, I believe that the time out of the DMT room and connecting through playing board games on the unit was imperative to the development of the relationship between Jairo and me.

Reward system. Prior to the session in which we were banned from the DMT room, I set up a reward system for Jairo. Though the teddy bear he found in the DMT room was not his, after discussions with my supervisor, I utilized the bear as a reward he could earn after he had four positive transitions at the end of therapy sessions. When I first introduced this to him, he seemed skeptical and did not trust that I would give him the reward in the end. During the sessions on the unit I reminded Jairo of his positive behavior and the teddy bear that he would receive if it continued.

Jairo and I had two successful transitions during the first two sessions on the unit. During the third session, Jairo gave me some of his Valentine's Day candy and a sticker he had received at school. Was this his effort to reach out to me as well, his way of showing his affection toward me? It would seem that he was beginning to make progress toward his therapy goal of engaging in mutually rewarding interactions. I personally was rewarded by this interaction; I was warmed by the gift Jairo was bestowing on me as it meant much more than just a tangible object. In the last ten minutes of this particular session, we played baseball together in

the gym with yet another successful transition to the end of the session. The next session was our fourth consecutive session of successful transitions and was also our first session back in the DMT space. At the conclusion of this session, Jairo was rewarded the teddy bear as a result of his positive behaviors in four consecutive sessions.

Jairo was unable to trust that I would follow through and reward him with the teddy bear. With the teddy bear as a symbol of nurturance, perhaps Jairo was also testing whether I could provide him the nurturing he was seeking and had not received from his own mother as a young child. Could I give him the structure, stability, and comfort he so badly desired? I believe that by following through and rewarding Jairo a tangible symbol of nurturance, I was able to gain his trust. After having established our relationship while on the safety of the unit, we established a reciprocal trust that I would be able to keep Jairo safe and he would be able to manage his behaviors during our sessions. In the next four months of therapy together, despite his problematic behavior and run attempts in other contexts, I no longer had to call for back up when with Jairo. I felt comfortable in our ability to keep one another safe within the therapy space.

The use of the teddy bear as a reward was twofold, it provided both a cognitive behavioral based approach through conditioning positive behaviors and allowed for Jairo to repattern his attachment style through a relational therapy approach. In children with disorganized attachment styles, the child is unable to trust and rely on the parent since the caregiver provides abusive or inconsistent care (Siegel, 1999). Jairo had come to believe that all care and relationships were as inconsistent as his initial attachment relationship. By following through in rewarding Jairo with the teddy bear, I was assisting Jairo in repatterning this belief. In a sense, I was utilizing treatment focused on the core principles of attachment theory by mirroring an appropriate caregiving environment in providing consistency, environmental safety,

emotional stability, and reflective interaction to Jairo (Corbin, 2007; Hardy, 2007; Hornor, 2008). According to Sossin and Loman (1992), "a safe holding environment is necessary before either empathy or trust can be created and maintained, whether in the therapeutic alliance or in a mother-child relationship" (p. 41). I was providing this holding environment for Jairo.

According to Corbin (2007), some research is less supportive of attachment based relational interventions. It is, therefore, important to note that cognitive behavioral approaches have been found to be useful in working with children who have been abused or neglected (Buckner, 2008; Hanson & Spratt, 2000; Mukkades et al., 2004). In earning the teddy bear, Jairo was being tangibly rewarded for his positive behaviors, a phenomenon which he later touted as the cause of his improved behaviors. The behavioral approach to therapy in which Jairo worked toward a concrete reward for his positive behavior proved useful in managing the environment and setting the stage for developing a therapeutic relationship with Jairo.

From Hopeless to Hopeful

My positive feelings after having rewarded Jairo for his positive behavior in four consecutive sessions did not last long. The morning after Jairo earned the teddy bear I received a phone call from my supervisor. Jairo had led several of his peers off the unit early that morning and he and his peers completely destroyed several rooms in the front office space of the facility. Jairo had gotten a hold of a fire extinguisher he sprayed through the office area. The boys knocked over computers and tore objects off shelves.

After I got off the phone with my supervisor I cried. It seemed as though the progress Jairo and I had been making in therapy with one another, the relationship I was beginning to establish with him, was all for nothing. I realized that as much as I wanted to help and protect Jairo, I could not keep him safe and I felt absolutely hopeless. Jairo had only known chaos

throughout his life, stopping at nothing to reestablish it for himself through destruction and I did not possess the power to save him from those experiences. It was at this point I began to realize my limitations as therapist. I could not become Jairo's replacement caregiver. I could not be there for Jairo at all times. I had to let go and continue to let my skills as therapist emerge in order to allow Jairo's skills to grow so he could learn to manage his own behaviors when I was not present.

Prior to this occurrence, I attended Jairo's first quarterly treatment review since beginning my work with him. Jairo attended part of this meeting, during which time he came in and hid behind a table. He was unresponsive and unable to engage with anyone in the room. At the end of the meeting, the facilitator remarked, "He'll be here for the long haul." Many others shared these sentiments and I had to admit, Jairo's prognosis did not look good. I had read the statistics and I saw antisocial personality characteristics present in Jairo's behaviors. Although the statistics suggest that children living in residential treatment facilities have high rates of incarceration (Dore, 1999), I was hopeful that Jairo would be different.

This topic and my personal beliefs came up in a later therapy session with Jairo when we had a conversation about his mother being incarcerated. I asked Jairo if he wanted to or ever thought he would go to jail. Jairo stated that he did not want to go to jail and that people only went to jail if they did very bad things, things like his mother had done. At this time, Jairo did not wish to discuss the things his mother had done any further. I suggested that over time, Jairo might talk about and work through his thoughts and feelings so he would not end up in the same place as his mother. I reinforced Jairo's positive qualities and instilled my hopefulness that he would never end up in such a situation.

In my second month of therapy with Jairo, my supervisor informed me the therapy schedule would be changing. She informed me that I could choose to stop working with clients with whom I was having difficulty, add clients with whom I was interested in working, or see some of my clients twice a week. The first name that came to her mind of possible clients I could drop was that of Jairo's. She was shocked and surprised when I informed her that I wanted to start seeing him twice a week. The hopeless feelings I had in response to Jairo's destructive behaviors turned to hopeful feelings that I could somehow make a difference by spending yet more time with him. It was also at this time that I began to feel drawn toward Jairo and began to consider writing a case study on my experiences working with him for my thesis project.

Contexts of the Relationship

Groups. Another reason I had wanted to begin seeing Jairo twice a week was the disparity between his relationship with me in our individual therapy sessions and our relationship when I saw him in passing on the milieu or during the group I co-led once a week. I could have a positive individual therapy session with Jairo on Friday and by Monday when I saw him in group therapy it was though he did not even know me. In addition to the disparity of Jairo's behavior toward me between group and individual sessions, Jairo also responded negatively toward me when I attempted to meet with him outside of his regularly scheduled therapy time. In our impromptu sessions, Jairo's demeanor toward me was much different than when he was prepared for session. Jairo was less welcoming and was often unwilling to stay for the whole session when he was not adequately prepared for the session. I quickly realized that Jairo would need ample time to prepare for changes in schedule.

It was as though Jairo had different selves that he brought forth depending on the contexts of the interactions. When meeting outside of his regularly scheduled therapy

appointment, Jairo was unable to prepare and access the warm welcoming self he otherwise brought forth during our sessions. The self Jairo brought forth in groups was especially challenging. The group context was in sharp contrast to individual sessions when he was one-to-one with a stable adult who was able to attune to his needs.

In the group, there were other young boys with dysregulated behaviors to which Jairo responded. The self Jairo brought forth in group therapy was hyperactive, defiant, disrespectful, and unable to access the support of therapists or staff to regulate or negotiate peer relationships. His verbally threatening and physically aggressive behaviors toward peers resulted in conflict and volatile interactions within the group. I imagine in this group therapy context, with eight young boys with a variety of difficult behaviors, the self Jairo brought forth would need to be highly defensive and protective. In fact, often times, he would not make it through the entire group when he had been asked to leave due to his disruptive behaviors or because of his personal choice to leave the group early.

In the initial stages of therapy, one of the groups I co-led took place in the gym where Jairo did not have easy access to coming in and out of group due to it taking place off the unit. Jairo's behaviors as well as those of his peers' deteriorated and in order to maintain safety all of the children needed to return to the unit before the group ended. I asked Jairo to walk with me back to the unit. He was agitated and angry and told me to go away. The disparity of his behaviors toward me in the group versus individually had a tremendous effect on me. What happened to the Jairo that was beginning to warm up to me in individual sessions? I felt inadequate, how could I not help him to calm down and engage with me in our developing relationship?

In our session later that week, I informed him that I would be there even if he told me to go away. I told him how I cared for him and wanted him to show his positive qualities toward me in the milieu as he was doing in our therapy sessions. In a sense, I wanted him to be able to show his warm welcoming self in contexts other than our individual therapy sessions.

In other groups, Jairo's posture often took on a ball-like shaping quality. According to KMP, this shape is most prominent in early stages of development, particularly as a fetus and newborn (Sossin & Loman, 1992). In a sense, Jairo was reverting to this shape and earlier stages of development in order to self-soothe and self-regulate in the stressful context of group therapy. Jairo also reverted to this shaping quality in the treatment review group setting when he also utilized the ball shape upon his arrival by crouching into a small space hidden behind a table.

In addition to his posture reverting to this shape, I also observed Jairo reverting to the oral sucking KMP tension-flow rhythm during a group. According to Amighi et al. (1999), the oral indulgent rhythm develops, as an infant is sucking, such as in feeding. It is an important rhythm in the development of the attachment relationship, as it is a period that is crucial for a caregiver to attune to the needs of the infant. In this group, as an infant might, Jairo was unable to keep a toy out of his mouth, using it as a source of comfort and self-regulation. Jairo's return to this earlier tension-flow rhythm could be indicative of the disorganized attachment he had with his mother, his primary caregiver, during the stage when oral indulgent tension-flow rhythm would normally develop (Sossin & Loman, 1992). This notion follows the premise that tension-flow rhythms that did not fully develop in early childhood and infancy are repeated and utilized throughout life. Perhaps, Jairo was reverting to both the ball shape and oral sucking rhythm as a means to self-regulate during the difficult group therapy sessions.

In another group therapy session, Jairo once again engaged the regressive biting rhythm by hitting a peer over the head after his peer told him he was not a good dancer. To follow up, in our next individual therapy session, I empathized with and validated Jairo's actions and told him that I, too, would be upset if someone had been making fun of my dancing ability. Jairo was surprised at the validation. We discussed other strategies of coping that did not include physical aggression. At this time, I utilized the image of a turtle and his shell to illustrate one possible coping strategy. *The Incredible Years* (Webster-Stratton, 2005) uses a puppet named Tiny Turtle to help teach the concept of letting negative words of others bounce off his shell. I combined this imagery with the DMT concept of space bubbles (Kornblume, 2002) that I had already taught Jairo in group therapy. I encouraged Jairo to imagine that his space bubble was a shell that would enable him to bounce off the negative remarks from his peers. Jairo engaged in the intervention and decided he liked using a turtle shell or his space bubble as a boundary to bounce off peer's negative words.

In the next group, I noticed that Jairo chose to sit next to me during the group, evidence of proximity seeking behavior and possibly using me for affect regulation during the group. Bowlby (1969) observed proximity seeking behavior when he first hypothesized attachment theory. He had noticed that infants seek out their attachment figure in situations causing them distress. Jairo's seeking me out in the group therapy context may have been evidence that I was similar to an attachment figure and a person he could go to for protection during the group.

At this time, I began seeing Jairo individually for a half-hour relationship building session before the group on Mondays, in addition to our individual DMT sessions on Fridays. I thought that if there was less time in between our individual therapy and group therapy, he might display less disparity in his interactional style with me in the different contexts. In the first group

we had back to back, Jairo was playful with me, first taking a prop without asking, then playing keep away from me. According to KMP tension-flow rhythms, this type of behavior correlates with the development of the twisting rhythm when the child is playful, teasing, and coy (Loman, 1996). Perhaps its appearance in connection to me exemplified the connection he was beginning to experience with me. Jairo also continued proximity seeking behaviors by consistently choosing to sit next to me. Jairo was using our relationship to help repattern his style of relating to others. Jairo was shifting away from his disorganized attachment style. This was a difficult task for Jairo and he would pull away at times, especially those in which he was having difficulty with peer relationships. At these times, Jairo displayed inconsistency and mixed emotions in relating to me.

Jairo's mixed behaviors in the group therapy sessions continued throughout the course of the five months we worked together. He showed interest in the physical activities of group, but was often unable to participate verbally. Jairo displayed significant improvement in his relationships with adults, yet he was unable to extend these positive relational qualities to interactions with his peers. Though this was the case, it is also important to note that the peers with whom Jairo was interacting also had highly inconsistent behaviors. It was easier for Jairo to interact and develop relationships with adults whose actions were more dependable and reliable. Perhaps his peer's behaviors were similar to those of his primary caregiver in his early childhood experiences, volatile and unpredictable. Even so, Jairo was unable to utilize the positive relationships he had established with several adults to help him regulate his emotions and resolve conflicts with peers.

On the milieu. The dynamics of working at a residential treatment facility, where I was working in the living environment of my clients, proved to be a challenge for me. It was difficult

for me to negotiate the relationship in and outside of therapy, and my relationship with Jairo was no exception. It was hard for me to have such an intimate relationship with clients in their allotted 45 minutes of therapy, but then to have that relationship feign existence once on the milieu. I found myself feeling guilty when Jairo would see me with other clients or when I had to end his session in order to get to my next group. In addition, I also experienced feelings of jealousy when I would hear about Jairo's interactions with other clinicians or staff. As a novice clinician, it was difficult for me to accept the limitations of the therapeutic relationship.

Jairo's behavior, when I saw him in passing in the halls, corresponded to my own confused feelings. When I saw Jairo on the milieu, he would barely acknowledge me with unchanged facial expressions and averted eye contact. I struggled to make sure Jairo realized the specialness of our relationship, though I also had relationships with other clients. I realize now that this specialness came across not only to me but to his peers as well. As I led my last group on their unit and informed the clients of my departure, many of the young boys asked me, "Who will be Jairo's movement therapist then?"

Transitions. As in the beginning, Jairo continued to struggle with transitions after our session was over. In one session, when prompted for the time to end, Jairo became dysregulated and hid in a small cupboard in the DMT room. In this space, for which Jairo's body was the perfect size, his posture once again took on a ball shape quality. Jairo was *retreating*, *descending*, and *enclosing*, basically closing in on all three dimensions where movement occurs (Amighi, Loman, Lewis, & Sossin, 1999). This was a common shaping quality for Jairo to utilize when he was affectively dysregulated. Ball shape and the cupboard in the DMT room also became a safe place for Jairo, a place which he utilized when dysregulated while in the space with me. Though in this comforting position, there did not appear to be signs that Jairo

was using this space for self-soothing. Instead, Jairo was activating both fight and flight of the fight or flight response. By hiding, Jairo was trying to escape the dysregulating event, though he often continued to fight back verbally in these hidden spots.

As therapy progressed, Jairo continued to have difficulty with transitions, but in a much more positive way. In later sessions, instead of acting out negatively at the end of session, Jairo would state things such as, "I want to stay with you," or he would prolong our session by not responding to prompts for cleaning up. At the time, I regretted that I could not give Jairo more time. I felt guilty for having to end Jairo's session in order to get to my next group. In retrospect, I should have addressed Jairo's difficulty in transitions or at least been more aware of their presence. It has not been until going over my notes in writing this case study that I noticed this theme and my lack of therapeutic response to Jairo's difficulty in saying goodbye at the end of sessions. I had let my own feelings of regret and guilt, my countertransference, get in the way of recognizing Jairo's patterns and needs.

Struggles and Successes in Finding My Way as Dance/Movement Therapist

As a dance/movement therapist in training I put a lot of pressure on myself for my DMT sessions to look a certain way. I expected dancing, movement, and therapeutic experiences much as I had seen in my training groups. But as I struggled to figure out what DMT would look like in real sessions rather than mock sessions, so too did my clients struggle to meet my expectations. It seems that many of them, including Jairo, viewed their DMT groups, much like their recreational groups, almost as a break from working on their treatment goals. In response to my attempts to address Jairo's treatment goals in therapy, he stated, "We're not supposed to talk about that in here." We struggled to figure out what DMT would constitute in our sessions. With his previous dance/movement therapist, he had resorted to playing computer games and

with me, the electronic keyboard became his security blanket, his way of avoiding interaction with me. I struggled with Jairo's unwillingness to participate in movement interventions. My feelings of inadequacy came up once more. I felt hopeless to create movement. How could I call myself a dance/movement therapist when nothing movement related or therapeutic seemed to be taking place?

An interaction with Jairo on the milieu in the second month of my internship prompted my realization that DMT and my skills as a dance/movement therapist were not required to be so concrete and could even extend beyond the DMT session. Jairo had been in the opportunity room, a space off the unit that gives the children a place to calm down when their behaviors are unsafe and also a place where restraints often occur when the children are a danger to themselves or others. I witnessed Jairo in this space as his behaviors escalated and eventually required a physical restraint. As per guidelines of the facility, the physical restraint was done in such a way so as to restrict Jairo's movement in order to provide safety without restricting his breathing or injuring him in any way (Residential Child Care Project, 2001).

While Jairo was in the restraint, I attempted to verbally assist him in calming down enough so he could be released from the restraint. I noticed his feet moving and began to state that it looked like he was writing something with his feet. I encouraged Jairo to expand the movement in his feet and, shortly thereafter, Jairo was released from the restraint and was able to process his behaviors. This small in-the-moment movement intervention assisted Jairo in taking his focus off the crisis and to engage in more positive use of physical expression. Prior to being put in the restraint, Jairo had been utilizing the biting tension-flow rhythm by throwing objects at his staff. Through my intervention, Jairo modulated to engaging the twisting tension-flow rhythm in exaggerated movements with his feet. Had I not created this intervention, it may have

taken Jairo longer to calm down before being released from the restraint. It was these little interventions utilizing movement expression and DMT that could help create change within Jairo and other clients like him.

Outside. When the weather turned warm, Jairo became interested in spending sessions outdoors which seemed like a more natural setting for him to feel comfortable with movement. The outdoor environment gave us an opportunity to relate to one another in a more natural childhood setting. At first, Jairo had difficulty engaging with me in these sessions. I would tag along with him as he engaged in exploring the outdoors. Eventually, the natural outdoor setting seemed to take away pressure from the intimacy of DMT interventions. Jairo began to respond to prompts to engage me in play and gradually our time outdoors became more relational. Ultimately, the outdoor setting and the time we had spent together establishing the relationship through board games enabled Jairo to feel a bit more comfortable talking about some issues related to his past. We were able to talk about his parents as well as past foster care homes in this outdoor environment.

Conflict. Later, when we began seeing one another twice a week, I established the rule that our Friday session would be spent in the DMT space. This way we could spend one session fostering our relationship, as we had been doing in our outdoor sessions, while the other we would more actively attempt to address his treatment goals through interventions in the structured environment of the DMT room. These first few sessions back in the DMT space were difficult ones. In the first session back, Jairo once again returned to a ball shape within the protected walls of the cupboard. The body sac I had brought for use in this session was of little use movement-wise, with him hidden away in the cupboard. Instead, I met him where he was and used the body sac to protect him further by putting it over the opening of the cupboard.

Perhaps my skills as therapist were shifting and emerging even further. I was able to utilize an in the moment intervention with flexibility and adaptations for Jairo's needs. The cloth over his hiding place provided Jairo the boundary he needed and he was able to engage with me verbally as we welcomed ourselves back and created safety in the space.

In the second session back in the DMT space, Jairo spent the majority of the session aiming a Chinese Yo-Yo at my head. These movements, when observed through a KMP lens, can be correlated with the biting tension-flow rhythm. According to Amighi et al., (1999), this is the oral fighting rhythm and is normally the second tension-flow rhythm to develop. In an infant, this rhythm develops as he or she begins to teethe. This is when an infant begins to differentiate the self from the caregiver, and will engage in snapping or biting movements, often directed toward that caregiver. This rhythm is correlated with establishing boundaries, concentration, and separation (Amighi et al., 1999). In this instance, Jairo was now directing this biting type of movement toward me with the Chinese Yo-Yo as a prop. This may have indicated his desire to establish boundaries and separation from me in our relationship.

I felt hurt and slightly violated that he was directing the movement toward me. Yet he was being safe, staying at a distance where the Chinese Yo-Yo would come back to him before it hit me. Jairo was unable to verbalize his feelings when I asked him why he was directing the motion of the Chinese Yo-Yo toward me. I remained calm, not wanting to reprimand him from this relatively harmless behavior. Utilizing KMP, this type of aggressive movement is seen as part of normal progression and should not be prohibited (Loman, 1996). According to Loman, the therapist can assist the client in channeling these types of aggressive movements appropriately. In this instance, I continued to allow him to explore the biting tension-flow

rhythm through movement. Jairo was eventually able to establish a sense of self in the session and relate to me more personably later in the session.

These biting movements occasionally continued to occur at the end of our sessions together as well, when Jairo would literally make a biting motion when I said goodbye to him. At the time, I was not sure what I had done that had led to Jairo direct these movements toward me. What had happened to the relationship that we were forming? What happened with all the progress we had made? I began to wonder what I would have to write my thesis about, what if therapy with me failed? I was once again taken aback by conflict and confrontation. As in the beginning when I felt uncomfortable with conflict and had been reluctant to address issues, Jairo was once again teaching me as emerging therapist about the need for both conflict and confrontation in developing a healthy relationship where communication is open and flowing.

In KMP terms, it is important to utilize the pleasant and soothing tension-flow rhythm as well as the aggressive tension-flow rhythm of each of the psychosexual phases. This concept is similar to that of Erickson's crisis stages in the psychosocial model (Erickson, 1950). Erickson theorizes that during infancy, a child is navigating the crisis of trust versus mistrust, an important aspect of the attachment relationship. In establishing trust, it is important for the infant to also work through the negative aspect of mistrust. According to KMP, continual healthy development will involve periods of attunement as well as conflict in the relationship between caregiver and child (Kestenberg, 1965). In KMP, an infant first develops a relationship with a caregiver in the oral indulgent tension-flow rhythm. According to Sossin and Loman (1992), complete attunement and synchronicity becomes maladaptive once the initial symbiotic oral sucking stage has passed. It is important for that infant to also establish a sense of self through the oral fighting tension-flow rhythm. Jairo appeared to be using this rhythm with me to set

boundaries and remain separate. The presence of the biting tension-flow rhythm may signify that Jairo was developing a sense of self through his therapy experiences and our shared relationship.

Plants as an intermediary. Most notable from our experiences outside was Jairo's interest in plants and nature. The idea of life versus death became a theme for him in our outdoor experiences. I wanted to explore this concept further and the context of the changing season provided us with the opportunity to examine sprouting life more closely. Planting our own seeds would provide the context within which to explore the concept most readily. In the session in which I brought the supplies for potting seeds, I arrived on the unit to find Jairo in the corner of his room, in a box, once again utilizing ball shape. He was yelling at staff sitting by his door, again in the fight/flight combo of hiding and yet verbally lashing out. When I asked him what was wrong, he stated that staff would not go away. When I asked him if I could come in to talk to him about it, he did not respond. When I waited, prompted again, and then approached anyways, he did not tell me to go away as he previously may have. I was able to attune to him, calm him down, and encourage him to take his medication, a refusal that had started the negative acting-out behavior. He was able to calm enough to go outside for our session. This event is an example of a dramatic shift in Jairo's behavior toward me, an indicator of the trust that was forming in our budding relationship.

Once outside and regulated, Jairo inquired about the bag of supplies I was carrying. Jairo was excited to engage in planting seeds with me. When planting the seeds he initially tried to tell me what to do, but then was able to listen to my instructions. There was give and take in the relationship, though he listened to and followed my directions, I also allowed him to put more seeds in his container than I normally would. It was as though there was a letting go on each of

our part. Jairo was teaching me to let go of control. At the same time, Jairo was letting go to the point of allowing me to nurture and teach him.

While Jairo and I were planting, we were utilizing a crouched ball shape. In this instance, the ball shape looked different than the one Jairo inhabited when affectively dysregulated. For the first time utilizing ball shape, I noticed Jairo enclosing toward me rather than away from me as he had in the past. As we crouched, we were able to work with one another rather than against. We were able to let go. In essence we were engaging in his goal of developing a safe, healthy, and mutually rewarding interpersonal relationship. This particular interaction was rewarding for me, I left the session with warm feelings of connectedness toward Jairo. Jairo's bright affect upon returning to the unit was in stark contrast to how his agitated state at the beginning of the session.

We grew these seeds in the DMT space, and the plants became a way to get Jairo engaged in coming to therapy in order to water his plants. Jairo's nurturing qualities were reinforced and exemplified in his care for his plants. He displayed concern in making sure his plants received just the right amount of water. In essence, caring for the plants was helping to repattern some of Jairo's relational qualities. Jairo's display of nurturing characteristics would negate the finding that children who have been neglected in early childhood are not receptive to replacement experiences such as therapy (Corbin, 2007).

The plants sprouted quickly but were breaking off because of the location where they were stored and the small containers in which they were growing. This was very upsetting to Jairo and brought us back to the theme of life versus death that I had noticed earlier on during our outdoor play. In the discussion we had about death, Jairo was unable to process his strong emotions further, only stating that all things die eventually. Due to his strong emotions, I felt

this was an area that needed to be explored further, yet he made it clear that he was not yet ready for that. As a result of the death and loss he experienced in his lifetime, I could see why he must have the notion that all things either die or leave eventually. Instead of addressing death further, we focused on fostering and supporting life by nurturing the plants.

For our next session, we planned on repotting the plants. As I arrived on the unit for this session, Jairo excitedly shouted my name. Jairo again had concern about the stems that did not look healthy and wanted to destroy them completely rather than salvage them. It was similar to what happened with his spider web and his behavior on the unit. It seemed like when things started to have a poor outlook, Jairo wanted to give up and sabotage completely. By acting out in ways of sabotage, Jairo was regaining some of the control such as he did when he led his peers in the destruction of the office space a few months prior. Jairo's reaction to the unhealthy plants could be related to a disorganized attachment. The relationship between an infant with a disorganized attachment style and his or her caregiver presents the infant with an unsolvable and problematic situation in which the child cannot use the parent to become soothed because the parent is also the source of disorientation (Siegel, 1999). In response to a stressor, a child of inconsistent parents will react in a disorganized way, as Jairo did when his plants were unhealthy. He was giving himself control in a situation that seemed as though loss might be inevitable or at least unpredictable.

Instead of allowing Jairo to destroy the plant, we playfully negotiated keeping the plants alive, me as the protector of the plant and he as the destroyer. In our playfulness, I modeled for Jairo how to manage dysregulating events. Rather than destroying the plant, I was showing him how to nurture it back to life. The playfulness continued in this session as Jairo played in the water when we went to water the repotted plants. Jairo also reverted to some more childlike

behavior in this water play, even utilizing some baby talk. Jairo also allowed me to care for him in rolling up his sleeves so they would not get wetter than they already were. Perhaps Jairo was allowing me to help repattern some of his earlier childhood experiences with these caregiving interactions. In using attachment theory, I was attuning to his needs and this time he was able to accept the care.

In this session, I also introduced the symbolism of repotting the plant and the growth of the plant being similar to his growth in our therapy sessions together. Jairo was not keen on this analogy, stating that he was not like a plant, that he did not have roots. However, this symbolism was important for me, hence the title of this thesis "growing child." It seemed to me that Jairo's growth mirrored that of the plant in our time in therapy together. Witnessing that experience, the growth of both plant and child, had been such a beautiful and amazing experience. In the safe container of our relationship, with nurturing, guidance, and support, Jairo sprouted quickly. It was now time for Jairo to expand his growth to a bigger container where he could allow for growth in other contexts (see Appendix B).

Therapist as Historian in the Creation of a Pathway

Other than our work with the plants, Jairo rarely wanted to return to interventions between sessions. Whenever I brought up the spider web or other interventions we had done, he rarely wanted to return to them. In one session, Jairo started an activity at the end of session and was upset when he had to put it away. I promised we would do it the next session and by the time the next session came around, it was as though he had forgotten the project completely. Jairo's difficulty with long and short-term memory was a problem which Jairo self-identified as a challenging for him. With Jairo's difficulty remembering, I found it important that I be the

historian of our path in therapy with one another. Yalom and Leszcz (1995) identify therapist as historian as important for the client to connect events and experiences.

Perhaps Jairo's difficulty in remembering things was partly due to pathogenic care he experienced in early childhood. The right brain is important to the storage of memory, especially those memories with emotional content (Schore, 1994). Maltreatment in early childhood could potentially lead to deficits in the structures of the brain responsible for storage of memory (Klorer, 2005). According to Siegel (1999), experiences that occur early in life, during the normal period of infantile amnesia, will only be processed as implicit memory. These early "events may remain in an unresolved, unconsolidated form" (Siegel, 1999, p. 110). Siegel states that in the unresolved form, memories may be more likely to influence implicit recollections automatically and set the stage for emotional and behavioral difficulties without conscious awareness of the initial cause. He finds that the ability of the mind to integrate memories is severely impaired in individuals with disorganized attachments.

Jairo's lack of memory may have served as a protective mechanism, growing up in a chaotic environment in his first years of life. By not remembering the events, he was able to allow for some regulation in functioning in the world. By engaging with me in a therapeutic relationship, I was able to assist Jairo in repatterning his experience of an attachment relationship in which he could experience attunement. By acting as historian in the relationship, I was also assisting Jairo in creating new memories by creating a narrative of the new relationship.

Since some of our therapy was now taking place in the DMT room, Jairo discovered some textured circles amongst the props. We utilized these props to create a symbolic pathway of our therapy together. I served as historian by recalling events that had occurred and the progress he had made in the course of treatment and he would, in turn, choose a different

textured circle to represent each particular event. Though Jairo was unable to verbalize why he chose to place each texture or color where he had, he did seem thoughtful in taking time to deliberate how to create his pathway. Creating the pathway also gave us an opportunity to talk about where he wanted his path to end and some of the differences between biological families, foster families, and adoptive families.

Interestingly, these texture circles and the pathway we created with them was an intervention to which Jairo was willing to return. In the first creation of the pathway, it was somewhat chaotic with no identifiable order to how it was laid out. This chaotic beginning could be reflective of chaos he had experienced thus far in life. In the last creation of the pathway, it was much more linear, going across the edge of the room in one straight line with his favorite green circle with small spiny protrusions placed at the end of the line (see Appendix B). Perhaps Jairo's willingness to engage in this particular intervention was due to creating order, as evidenced by it becoming more linear. In engaging in the intervention, I was recalling for Jairo positive aspects of our relationship with one another and the progress he had made in therapy.

For me personally, this intervention and experience had been enlivening. It was amazing how easily and seamlessly it unfolded. I had not planned to use the textured circles the first time Jairo came across them. I was learning to let go and have Jairo be the guide in the therapeutic process. My skills as an emerging therapist were revealing themselves gradually without me realizing. Becoming the historian to our therapy also enabled me to see the progress we had made together, to have more confidence in my abilities as a therapist.

Progress in Treatment

The focus of Jairo's therapy sessions was to develop safe, healthy, and mutually rewarding interpersonal relationships. During our five months of therapy with one another, Jairo

made progress toward this goal in a relationship with me as well as with the other adults at the facility. One way this was evident was Jairo's shift from distrust toward me in the beginning to him showing excitement when I came to get him for our therapy sessions. Jairo and I consistently engaged in safe, healthy, and mutually rewarding interactions during our therapy sessions. Though we occasionally had a difficult session, Jairo and I were able to repair the disruptions in the relationship, often before the session ended.

After three months of therapy with me, Jairo made a dramatic shift in his willingness to engage in a relationship with his grandparents. Prior to this, Jairo had been refusing contact with his grandparents. Yet in the third month of therapy with me, Jairo began phone contact with his grandparents, and then by the fifth month he was having visits with his grandparents at the facility. This was a remarkable shift facilitated by Jairo's primary therapist, who also reported an improvement in her interactions with Jairo over the five-month time span. With this noteworthy shift, one might wonder if the relationship Jairo and I created together through DMT was helping him to set the stage for positive relationships with others as well.

Jairo's behavior toward me also shifted dramatically over the course of treatment together. In some of our first interactions together, Jairo laughed and made fun of me as we attempted to play badminton together. However, as therapy progressively continued, Jairo became accepting of my faults and abilities in certain games and even began to demonstrate helping qualities. Now when we played video games together, as a reward during a portion of our sessions, Jairo did not become frustrated at my inability to use the controller. Instead, he kindly offered his assistance. Jairo began to demonstrate concern and care for me while we were outside by pointing out puddles or branches that might be in my way. Jairo became concerned about how his peers treated me, as evidenced by how he became defensive of my name being

mispronounced by his peers. Jairo was now demonstrating empathy for me and others. This empathic quality was something Jairo had not previously demonstrated, its development being correlated to positive early attachment experiences Jairo had not encountered (Berrol, 2006).

During our therapy sessions, Jairo became more accepting of the limits and boundaries provided for him. Jairo began to demonstrate more flexibility in the timing of our session when I had scheduling conflicts during his regularly scheduled therapy session. Upon seeing me in the doorway to his room on a day we did not have scheduled for therapy, Jairo greeted me warmly and became willing to engage with me without needing advance warning of a scheduled session. Jairo established a sense of trust and safety with me and was learning to make adjustments and work with me.

Jairo's flexibility also became apparent in some movement interventions. Jairo's movement demonstrated flexibility when we maneuvered in and around trees in our outdoor sessions, and in our water play by creating swirling motions in the water together. These movements were demonstrative of the next KMP rhythm to develop after the biting tension-flow rhythm. This rhythm, known as the twisting tension-flow rhythm, is correlated to adaptability and flexibility. Normally, this rhythm begins to readily appear when an infant becomes mobile and must twist and adapt to the space around them (Loman, 1996). For Jairo, it was appearing now in the adjustments he was making in relationship with me.

Many of the individuals involved in Jairo's treatment were interested in the shifts in his behavior. In the second quarterly treatment review, I spoke of Jairo's shift in movement qualities. As therapy progressed, Jairo spent progressively less time in ball shape. He began to be more upright and vertical, displaying posturing that is often correlated with a stronger sense of self. In my comparison of how Jairo came in and hid in his prior treatment review, the clinicians

were interested in how Jairo would come in for the current treatment review. Jairo came in confidently, choosing the seat next to mine. In speaking with his caseworker, he stated that in Jairo's year and a half at the treatment facility, this treatment review had been, by far, the most positive.

Termination

In the last couple of weeks in therapy together, Jairo began to display some regressive behaviors such as withdrawing and refusal. In the session a week prior to my last day, I attempted to address my upcoming departure with Jairo. I verbally expressed my affection for Jairo, stating that I would miss him and that I very much enjoyed working with him. Jairo was avoidant; he did not appear as though he wanted to address the topic of me leaving. Instead, he began creatively playing with the chess pieces that were before him. As Jairo utilized the chess pieces to attack one another and implicitly process our conversation, Jairo verbally attacked me, stating that I hated him. When I attempted to tell him otherwise, Jairo called me an idiot and continued to be disrespectful.

Although Jairo's play with the chess pieces and his demeanor toward me appeared aggressive, I was able to reflect on the therapeutic progress represented by his actions. The use of pretend play with the chess pieces in this session was indicative of the shift Jairo had made in relational skills associated with right brain processes. Before Jairo was more apt to engage in left brain processes normally activated by a game of chess. Now Jairo was utilizing the chess pieces for right brain process of creative play. I was in awe of this dramatic shift. On the same note, in discussions with the art therapist, she described Jairo's shift in the medium he chose to use for his artwork. Rather than concrete, Jairo began choosing more malleable art materials such as watercolors. Jairo was beginning to be able to engage more creatively and flexibly.

A factor that may have contributed to Jairo's regressive behaviors as I facilitated the termination process included an unexpected phone conversation he had with his mother. This would have likely triggered mixed feelings given her inconsistency of care and contact throughout his life. Jairo was also experiencing a transition at the residential treatment facility, being moved into a room with a roommate in attempt to facilitate more positive peer interactions. Up until this time Jairo had a room of his own due to his high-risk behaviors. Positive interactions with his roommate did not last long. Shortly after the move, Jairo began to revert back to high-risk behaviors including several attempted elopements from the facility. Perhaps Jairo was also anticipating the end of my internship. All of these events combined were likely overwhelming and became too much for Jairo to regulate in these last weeks of therapy, hence the regressive behaviors.

In our second to last session, Jairo was withdrawn and showed little acknowledgement of me when I came on the unit to get him. As we walked down the hall, it became clear that Jairo did not seem to be in a good mood. When he stopped to get a drink of water, one of his peers hit him in the chest. Jairo collapsed to the ground in hysterical tears, clearly dysregulated and unable to handle the situation. In this situation, Jairo allowed me to nurture him through attunement, touching his arm, and helping him regulate through breath. Jairo's welcoming reaction to my nurturing qualities in this situation was indicative of his ability to utilize our relationship for affect regulation.

Final session. As I began to nervously anticipate our final session, I was filled with many different feelings and expectations. I felt sad, and even guilty, that I had to end my relationship with Jairo. As a neophyte clinician, I experienced my own insecurities, wondering if the relationship was as special to Jairo as it had become for me. On one hand, I braced myself

for the worst, knowing that Jairo had been having a difficult time in the last few weeks and had struggled in our last few sessions. This part of me did not expect a heartfelt goodbye, but rather a lot of angry feelings toward me for leaving. On the other hand, I had high hopes for our final session together, wanting to spend time with Jairo and relay to him how important he had become to me.

My plan for the session had been to assist Jairo in creating a path to his primary therapist's office with our texture circles. We would then walk the pathway with our plant and find a new place for it in her office. For me, this was an intervention filled with symbolism. Though the path Jairo had walked with me during therapy together was ending, he would now extend his growth out to other relationships. The picture perfect plan I had for this session did not unfold as anticipated. Jairo arrived home from school that day upset that he was receiving a consequence for behavior he displayed earlier that morning. As Jairo saw me in passing, he asked if he could just meet with me right then rather than at our scheduled time. I was able to honor his request.

As we walked to the DMT room, Jairo's irritation about the consequence quickly shifted and Jairo began displaying playful behaviors. Despite his playful demeanor, Jairo did not share my enthusiasm for creating a pathway through the building. In this instance, I was able to let go of my planned interventions and let the client take the lead in what he needed. Though I experienced some disappointment, Jairo had taught me to let sessions unfold or emerge as they would. I knew that the session was not about me and my needs, but rather Jairo and his needs. Letting go would allow for what Jairo needed to take place rather than forcing a path through the building that had no meaning for him. Jairo was a catalyst for me in letting go and for letting my

skills as a therapist emerge. I did not need to follow a set of guidelines. I could trust Jairo and let him be my guide.

During our termination session, one of the things Jairo needed was to show me his "secret" spots in our time outside together. In this walk outside, I asked about how he was feeling about me leaving. Jairo demonstrated neither a heartfelt expression of positive feelings for the relationship, nor did he express anger toward me for leaving. It seemed as though Jairo was not fully grasping that he would no longer be seeing me. This may have served as a protective defense mechanism for Jairo; if he did not acknowledge my departure, then he would not have to process it either.

In this session, I struggled with Jairo's apathy toward me. Jairo meant so much to me, and yet he was not displaying any strong emotions toward me, positive or negative in nature. I felt empty and sensed a lack of closure, not only with Jairo, but also in leaving my internship and the rest of the clients with whom I was working. My response to these feelings was to prolong the session, wanting for something more to happen, wanting to spend more time with Jairo. In past sessions it had been Jairo that had difficulty transitioning to the end of the session, but this last time together it was I for whom the transition was difficult. This time it was not Jairo who did not want the session to end, but me who did not want it to come to a close.

These lingering qualities were not new for me in the ending of relationships. After my experiences student teaching, I continued on with my students by serving as a substitute teacher in the next semester. When teaching, I assisted with summer school because I struggled to trust that certain students would be able to manage without me. In my relationship with an infant for whom I was a nanny prior to beginning my internship, I struggled to make a clean cut by

continuing to babysit and stop by his house to see him. Also, in romantic relationships, I hold on, remaining friends with individuals to whom I have developed strong connections.

Though I had struggled with saying goodbye in other situations as well, the feelings I experienced in this situation felt different than in any other transition to an ending I had in the past. I wondered if the lack of closure and emptiness I felt in relation to terminating my internship was in response to terminating with clients who often had people leave their lives in unhealthy ways. Perhaps the lack of closure I felt was due to saying goodbye to individuals who have never experienced a proper goodbye, children who had been ripped away from abusive caregivers or whose parents simply abandoned them without saying goodbye. I was saying goodbye to children who struggled with all aspects of relationships, who were unable to navigate through them likely due to insecure attachments in early childhood. My feelings of emptiness seemed to be mirroring experiences they had throughout their lives.

Reflections

As I said goodbye to Jairo in this last session, I was also saying goodbye to the training phase of my career as dance/movement therapist and counselor. Through the relationship we had created, Jairo had taught me about being a therapist and also about myself as a person. Though my growth and his had been tremendous, our journeys were not complete. I would continue to develop as an emerging therapist and he would continue his growth in other relationships. As an emerging therapist, I still have so much to learn about the field, about theories and interventions, about my style, about relationships, about saying goodbye, and about letting go. I have so much to learn about myself and my motivations and desires. My journey as an emerging therapist is only just beginning.

Writing this case study about Jairo and the relationship we created has aided me further in my development as a therapist. I have learned from ample reflection, from pulling our relationship apart and piecing it back together. Interestingly, I was learning about letting go through holding on to the relationship by writing about it so extensively. Instead of keeping the actual relationship going in one form or another as I had done in the past, my relationship with Jairo shifted to my relationship with my thesis. I was living, dreaming, and breathing the relationship, yet doing it all alone amongst books, papers, and my trusty computer. This forced me to look deeper, and in so doing, to let go.

It is my hope that through creating this relationship together with Jairo, he has also learned a little something about being in relationship and in saying goodbye. With our positive relationship and positive goodbye my hope is that Jairo will learn healthier ways of interacting with others separate from what he experienced in early childhood and being taken away from his own mother. As I look back, I realize Jairo had, in fact, developed a safe, healthy, and mutually rewarding relationship with me as his therapist. My hope is that he will continue these relationships with others.

Discussion

The purpose of this case study was primarily to present the challenges and successes of my process, as neophyte clinical therapist intern, utilizing DMT principles and techniques to facilitate the development of a positive relationship with a child with RAD. The primary goal of therapy with Jairo was to develop a safe, healthy, and mutually rewarding interpersonal relationship with one another. It was my hope that once Jairo was able to experience a positive relationship with at least one individual, he would be able to transfer that experience to other relationships. Although we went through many ups and downs over the course of five months of

therapy, I do believe Jairo make remarkable progress in the goal of engaging in a mutually rewarding interpersonal relationship. From my end of the relationship, I experienced enjoyment in and felt rewarded by many of my interactions with Jairo. It was reported by other clinicians as well that their relationship with Jairo had also improved over the five-month period of time in which I worked with Jairo.

Summary

The enjoyment I felt in sessions at the end of treatment with Jairo was in stark contrast to the feelings I had in the beginning of his treatment. In the beginning, Jairo and I struggled to connect with one another and he struggled with transitioning back to the unit after the session was over. This beginning was a challenge for me as I questioned my abilities, as therapist, to maintain a safe space. Since transitions were difficult, we conducted our sessions on the unit for a few weeks. During this time, I utilized a cognitive behavioral reward system and engaged with Jairo in more cognitively based board games. From reading the literature (Buckner et al., 2008; Hanson & Spratt, 2000; Mukkades et al., 2004) and reflecting on my own experiences in working with Jairo, I discovered the benefits of utilizing a more cognitive based approach when setting boundaries and structure in work with children with behavioral difficulties.

After connecting in this way, Jairo began displaying more empathic and respectful behavior toward me. Though this was the case during our individual therapy sessions with one another, his destructive behaviors and elopement attempts continued while on the unit. In group therapy, Jairo continued to be disrespectful toward me and was unable to use our relationship during times in which he was affectively dysregulated around his peers who also displayed behavior problems. I addressed these behaviors in individual therapy with Jairo by validating his feelings that led to his unsafe behaviors and providing support in his response to peers'

behaviors. At this time, I began seeing Jairo in individual therapy twice a week rather than just once during the week. After seeing him more frequently, Jairo began to be more respectful to me in groups and in passing outside of his regularly scheduled therapy session. This shift indicated a positive relationship was beginning to occur.

At this time, Jairo and I were also conducting his therapy outdoors in a more natural childhood setting. During our time outdoors, Jairo became more relational with me and able to talk about challenging topics such as family and his past experiences. It seemed as though many of the interventions that occurred outside were successful as we began to feel more connected in our relationship. We then brought the outside indoors and began growing seeds together in the DMT space. This intervention proved to be powerful for Jairo in bringing out his caring and empathic qualities. Another intervention that was successful for Jairo was the use of props to create a tangible path of the progression of therapy during our time together.

As a neophyte therapist, it was important for me to not simply equate positive feelings with the successfulness of the session. Jairo and I also had conflict throughout the course of our relationship together. Through this conflict Jairo taught me about the importance of confrontation and letting go. Working with Jairo, I learned that complete symbiosis and positive feelings toward one another is not a successful therapeutic relationship. Through biting tension-flow rhythms directed toward me, Jairo taught me the importance of establishing separateness. These periods of conflict can also be seen as success in the therapeutic relationship.

In the end, Jairo began once again to display destructive and dangerous behaviors. Though there were a lot of things going on for him such as a new roommate, contact with his biological mother, and the anticipation of my departure, Jairo was able to use our relationship for affect regulation at some points during this difficult time. When in the beginning Jairo's posture

displayed qualities of ball shape, now Jairo was more in the vertical and ready to address topics in therapy he had not previously been willing to address. I was also changed during my time with Jairo. He had taught me much about myself as a person and therapist during our time together.

Bridge Between this Study and Existing Research

Jairo showed progress across multiple contexts during our five months in therapy together. As an integral member of a treatment team in a residential treatment facility, I worked with others to meet the needs of Jairo in a comprehensive and sustaining way. This case study supports the results showing that children with severe emotional and behavior disorders can benefit and sustain positive outcomes from residential treatment that is multi-modal and holistic in its approach (Hair, 2005). Although the case study methodology has its limitations, in this instance the child in this study displayed remarked improvements over a five-month period.

When I first set out to complete this case study, my focus was on attachment theory and its relationship to providing treatment to a child who had early experiences of neglect. Research supports the notion that treatment for RAD should be focused on the core principles of attachment theory and that the therapist should mirror an appropriate caregiving environment by providing consistency, environmental safety, emotional stability, and reflective interaction (Corbin, 2007; Hardy, 2007; Hornor 2008). According to Dungey (2005), KMP compliments attachment theory and can be useful in highlighting movement qualities of children with attachment difficulties. Adding to Dungey's work, this case study follows suit by also utilizing KMP to describe the movement qualities of Jairo. This case study supports the finding that overabundance or lack of specific movement patterns are linked with trauma during particular developmental phases (Sossin & Loman, 1992). Most prominent in Jairo's movement was the

biting oral tension-flow rhythm, a rhythm that is normally most prominent in the first year of life. Overabundance of this tension-flow rhythm could be indicative of the pathogenic care he received in his first year of life.

This case study and the work of Dungey (2005) support my hypothesis that DMT is particularly beneficial in addressing the early attachment processes since dance/movement therapists utilize the body to attune with the experiences of clients. This process between dance/movement therapist and client is similar to that of an infant and his or her caregiver when communication is non-verbal. The caregiver must attune to and respond to their infant on a body level. Berrol (2006) supports this further in describing the similarities between the concept of mirroring in DMT and the concept of mirroring explained by neuroscientists.

Though focusing on attachment theory had been my original intent for this case study, from reading the literature and reflecting on my experiences in working with Jairo, I wondered what the effects would be in combining both cognitive behavioral as well as relational therapy techniques in the treatment of RAD. In a review of the literature, several sources declared that interventions that are useful in reducing behavioral symptoms for children with similar diagnoses to RAD are those that include cognitive behavioral management of mood symptoms, behavioral modification, and psychoeducation (Buckner et al., 2008; Hanson & Spratt, 2000; Mukkades et al., 2004).

My work with Jairo supported this need for cognitive behavioral based techniques in addressing the behavioral component of RAD. When Jairo had been asked what he felt contributed to his improvements in his behavior, Jairo stated that he was being rewarded more often for his positive behaviors. In Jairo's response, he was speaking of the tangible rewards such as the special snacks and extra privileges he received for his positive behavior. This reward

system is a common component of behavioral therapy techniques. Though the rewards were more tangible in nature, Jairo's positive behaviors also led to positive interactions with adults. As Jairo became more enjoyable to be around, he also began receiving more one-on-one attention on the milieu. In effect, Jairo was also receiving a less tangible reward of the experience of being in a mutually rewarding interpersonal relationship. Jairo was being intrinsically rewarded for his improved sociability. In my opinion, it was the more cognitive based approaches, such as being tangibly rewarded for his behaviors, that set the stage for me to use more attachment based approaches with Jairo.

Areas of Future Research

The success demonstrated in this particular case provides support for the use of DMT and other creative therapy modalities in treating RAD and other attachment related disorders. More exploration will need to be done in this area to further validate this study. KMP in particular appears to correlate well with attachment theory. However, KMP has remained largely unintegrated into attachment theory models of infant-parent psychotherapy (Amighi et al., 1999). The use of KMP language and knowledge remains isolated primarily to dance/movement therapists. Further research needs to be done in order to provide validity in relating KMP to attachment theory and attachment related disorders. In this case study, KMP was only utilized reflectively rather than as assessment or intervention technique during the course of treatment. The utilization of KMP for both assessment and treatment of RAD needs to be explored further in future research.

In addition to the use of KMP, this case study supported the need to provide structure and behavioral based approaches in the beginning in order to help facilitate the development of a relationship later on. With Jairo's need for cognitive behavioral approaches in the beginning, I

wondered, what would be the effects of utilizing a combination of both cognitive behavioral and relational therapy techniques for children with RAD? This concept requires exploration in future research. I intend to explore this concept further through my own work as a clinician as I develop my style and theoretical perspective. Though I may not continue this work in a formalized research setting, my growth and curiosities will continue as a budding dance/movement therapist.

Conclusion

Upon initiating this case study, my primary purpose was to present the challenges and successes of a neophyte clinical therapist utilizing DMT principles and techniques to facilitate the development of a positive relationship with a child with RAD. Most challenging for me during therapy with Jairo was figuring out my role as therapist. Though my intention was to mirror the qualities of an appropriate caregiving environment, I could not provide that environment at all times, as I was not his caregiver. I struggled with discovering my limitations as his therapist rather than his caregiver throughout my internship. I had difficulty terminating with him and regreted that our relationship could not continue through to the end of his placement at the residential treatment facility. Instead of describing the entirety of his treatment process, this case study examines only one portion of his treatment process. Our relationship ended when my internship ended rather than at the completion of treatment. This component has interesting implications, especially when considering that my departure may have contributed to his regressive behaviors in our last weeks of therapy with one another.

Despite feelings of regret, I knew I was not leaving Jairo high and dry, but with additional skills that would help him to relate to others at the facility in healthy ways. I still struggle and wonder about how corrective a relationship with reparative attachment-like

characteristics is when it only ends in another severed relationship. The children in these residential facilities are constantly moving with no one individual as a consistent figure in their lives. What then are the effects of another person leaving them behind? It is no wonder that Jairo and the other clients I worked with often had difficulty at the end of their sessions and in saying goodbye.

When reflecting on the successes of my relationship with Jairo, I am drawn to the primary goal of his therapy: developing a safe, healthy, and mutually rewarding interpersonal relationship. In many respects, we did develop this mutually rewarding relationship with one another during individual and group therapy sessions. Interventions that were successful and contributed to the progress he had made on this goal included: playing board games together and setting structure in the beginning, providing a tangible reward for positive behaviors, validating feelings leading to his behaviors in groups, exploring the outdoors, planting seeds, creating a pathway that assisted in creating a narrative of therapy together, as well as addressing conflict and allowing it to be a part of the relationship. In particular, the use of the plants was useful in promoting and highlighting Jairo's nurturing and empathic qualities. As I witnessed the growth of the plants, I witnessed a parallel growth process in Jairo. As Jairo made progress, so too did I as an emerging therapist. Together in the relationship we created, transformation ensued.

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Appendix A: Glossary of Terms

Attachment theory is a psychological, evolutionary, and ethological theory proposing that infant and parent are instinctually and biologically predisposed to become attached to one another, and that this attachment is necessary for the infant's survival. This theory proposes that the development of positive attachment relationships is essential to an individual's normal social and emotional development (Bowlby, 1969).

Attunement is the relational process by which one individual in the relationship such as a caregiver or therapist senses, feels, resonates with, and intuits the needs and experiences of the other individual such as the child or client. The caregiver or therapist synchronizes and/or harmonizes their affective state and movement qualities with that of the child or client in order to meet his or her needs (Dungrey, 2005; Levy, 2005; Siegel, 1999).

Dance/movement therapy (DMT) is the psychotherapeutic use of movement to promote emotional, cognitive, physical, and social integration of individuals (Levy, 2005).

Disorganized attachment is one of four attachment styles derived from the Strange Situation. It was later added after the original three (Main & Solomon, 1986). In this attachment style, an infant displays chaotic or disorienting behaviors such as going toward a caregiver and then backing away (Siegel, 1999).

Dysregulation is an individual's inability to manage his or her emotions in ways that fall within the conventionally accepted range of emotional responses. It may manifest in an individual destroying or throwing objects, acting aggressively towards self or others, as well as threatening to kill oneself. Dyregulation can be associated with experience of psychological trauma, brain injury, chronic maltreatment, or psychiatric disorders (Schore, 1994; Siegel, 1999).

Emotional and behavioral difficulties is a broad term referring to a variety of mental health conditions common in children and adolescents (Dore, 1999).

Kestenberg Movement Profile (KMP) is a complex observation system used to assess developmental movement characteristics in infants, children, and adults. Utilizing this system, movement characteristics can be analyzed utilizing a psychoanalytic framework (Kestenberg, 1965; Levy, 2005).

Mirroring is a form of empathic reflection by which a dance/movement therapist participates in a client's total movement experience such as their postures, gestures, and effort qualities. It is similar to Roger's concept of empathetic listening but through non-verbal means (Berroll, 2006; Dungey, 2005; Levy, 2005).

Pathogenic care is care in which a child has been abused or neglected, and/or lacks a consistent caregiver (APA, 2000).

Physical restraint is a hold in which trained staff restricts the mobility of a young person in order to contain behaviors likely to cause injury to the child or others (Residential Child Care Project, 2001).

Proximity seeking behaviors such as crying, calling, pursuing, clinging, and monitoring the whereabouts of the caregiver are the behaviors seen in infants that are instinctual and promote survival of the infant (Bowlby, 1969).

Reactive attachment disorder (RAD) can occur when a child suffers from persistent pathogenic care such as neglect or repeated changes in primary caregiver. A child with such diagnosis displays a social relatedness that is markedly disturbed and developmentally inappropriate (APA, 2000).

Residential treatment is a broad term describing a continuum of services such as substance abuse treatment facilities and facilities serving individuals with mental illnesses (Lee, 2007). However, in this paper, the term refers to a therapeutic facility, serving children with emotional and behavioral difficulties who are unable to function in normal home environments.

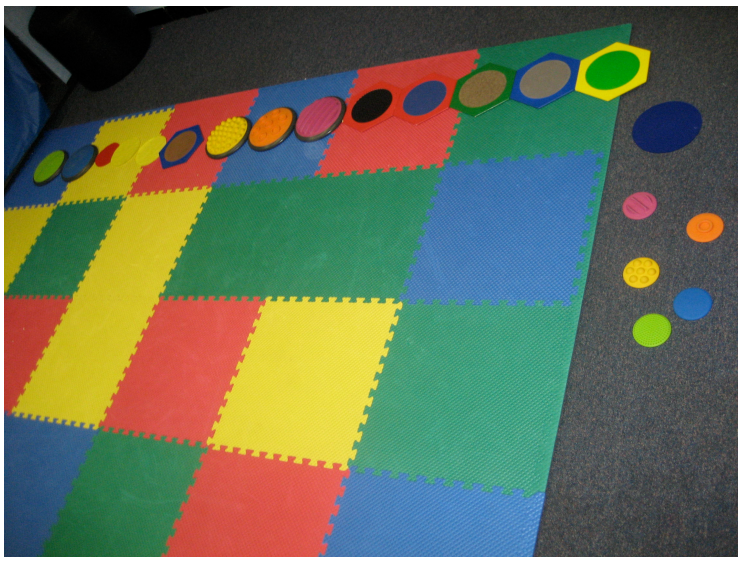
Shape-flow is a KMP term that refers to the growing and shrinking of the body in response to stimuli in the environment. An individual's shape-flow represents his or her emotional response to the environment (Sossin & Loman, 1992).

Strange Situation is a laboratory procedure used to assess infant patterns of attachment to their caregiver. Interactions between caregiver and child are examined before, during, and after separation phases of the procedure (Ainsworth et al., 1978).

Tension-flow rhythms are identified in the KMP system as discernible rhythmic patterns present in the body as a result of periodic alternations in muscle tension. They are developmental in nature and express the needs and drives that unfold as a child matures (Amighi et al., 1999).

Appendix B: Symbolic Photographs

The plant Jairo and I grew together as a part of treatment.



The path Jairo created representing the development of our relationship.